

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04261					04263				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Washington</u>					a. STATE <u>Maryland</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					b. COUNTY <u>Washington</u>				
c. LENGTH OF STAY IN 1b <u>3 years</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin Manor Nursing Home</u>					d. STREET ADDRESS <u>Canal Rd.</u>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Ardinger</u>					Month <u>March</u> Day <u>24</u> Year <u>19 67</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 29 1889</u>		9. AGE (In years last birthday) <u>78 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u> Hours <u></u> Min. <u></u>	
13. FATHER'S NAME <u>Charles Ardinger</u>					14. MOTHER'S MAIDEN NAME <u>Lula Woltz</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Mrs. Ida Ardinger</u>					Address <u>Canal Rd. Williamsport Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral broncho pneumonia</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced arteriosclerosis, generalized,</u> DUE TO (c) <u>+ cerebral thrombosis</u>									INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>5-10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1 -</u> , 19 <u>67</u> , to <u>Mar 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 11</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward W. Dill</u>					22b. DATE SIGNED <u>3-24-67</u>		22c. PHYSICIAN'S NAME (Type) <u>217 W. Washington St Hagerstown, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>March 27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>		
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Maryland</u>					25a. REC'D BY REGISTRAR <u>MAR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04262		CERTIFICATE OF DEATH				04264			
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Pennsylvania</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b> 75-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County</b>					d. STREET ADDRESS <b>26 W. 3rd St.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ethel May Balsiger</b>					4. DATE OF DEATH Month <b>3-</b> Day <b>10-</b> Year <b>19 67</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-02</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Franklin Co. Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Howard King</b>					14. MOTHER'S MAIDEN NAME <b>Minnie Schrader</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>- -</b>		17. INFORMANT <b>Mr. H. E. Balsiger</b>			Address <b>Waynesboro, Penna.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 296X IMMEDIATE CAUSE (a) <b>Gastrointestinal and intracranial hemorrhage.</b> DUE TO (b) <b>Acute thrombocytopenic purpura.</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>3-5-67</b> , 19__, to <b>3-10-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>3-9-67</b> 19__, and that death occurred at <b>3:45am</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>A. F. Abdullah</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-13-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>A. F. Abdullah, M. D.</b>					22d. ADDRESS <b>132 N. Potomac St., Hagerstown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/12/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro, Franklin, Pa.</b>			
24. FUNERAL DIRECTOR <b>Walter G. Shaw</b>					ADDRESS <b>Waynesboro, Penna.</b>		25a. REC'D BY REGISTRAR <b>MAR 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04265

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RFD #2</u>	
f. STREET ADDRESS <u>Pinesburg</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ezra</u> Middle <u>Keller</u> Last <u>Banzhoff</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14 1874</u>
9. AGE (in years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u>	11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>17</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fishing Guide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Banzhoff</u>		14. MOTHER'S MAIDEN NAME <u>Mary Unger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 03 1226A</u>	
17. INFORMANT <u>Mr. Amos Banzhoff</u>		Address <u>Williamsport Md RFD #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Brain Hemorrhage and contusion</u> 9000 } DUE TO <u>accidental fall down basement steps</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Accidental fall down basement steps</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> 3/26/67 p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Wmspt. Wash. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		DATE SIGNED <u>3/27/67</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M. D.</u>		DEPUTY MEDICAL EXAMINER <u>580 Northern Ave., Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 29-67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Md.</u>	
23. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md..</u>		24a. REC'D BY REGISTRAR <u>MAR 28 1967</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04264

04266

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leitersburg</b>		c. LENGTH OF STAY in lb <b>17 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rd # 5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>William</b> Last <b>Bingaman</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-06</b>
9. AGE (In years last birthday) yrs. <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Steel mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Welsh Run, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>John E. Bingaman</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Mummert</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>174-01-3577</b>		17. INFORMANT <b>Ella Bingaman</b> Address <b>Leitersburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to</b> <b>9731</b> DUE TO <b>Carbon Monoxide</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>15-30 Min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.		22. DATE SIGNED <b>3-13-67</b>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3-14-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro, Pa.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>		25a. REC'D BY REGISTRAR <b>15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04265

CERTIFICATE OF DEATH

04267

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>Rd 1</b>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Blanche</b> Last <b>Boppe</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indian Springs, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Grove</b>		14. MOTHER'S MAIDEN NAME <b>Anna Penner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Wm. A. Boppe</b>		Address <b>Cascade, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>578X Massive repeated hemorrhage into gastro-intestinal tract.</b> DUE TO (b) <b>Unknown</b> DUE TO (c) <b>intermittently 16 hours.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Atherosclerotic heart disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 14</b> , 19 <b>67</b> , to <b>March 15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 15</b> , 19 <b>67</b> , and that death occurred at <b>2:05</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>William T. Layman, M.D.</b>		22b. DATE SIGNED <b>March 17, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3-18-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>		25a. RECEIVED BY REGISTRAR <b>DATE MAR 20 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

04307

04307

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

*[Handwritten signature or initials.]*

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04266

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

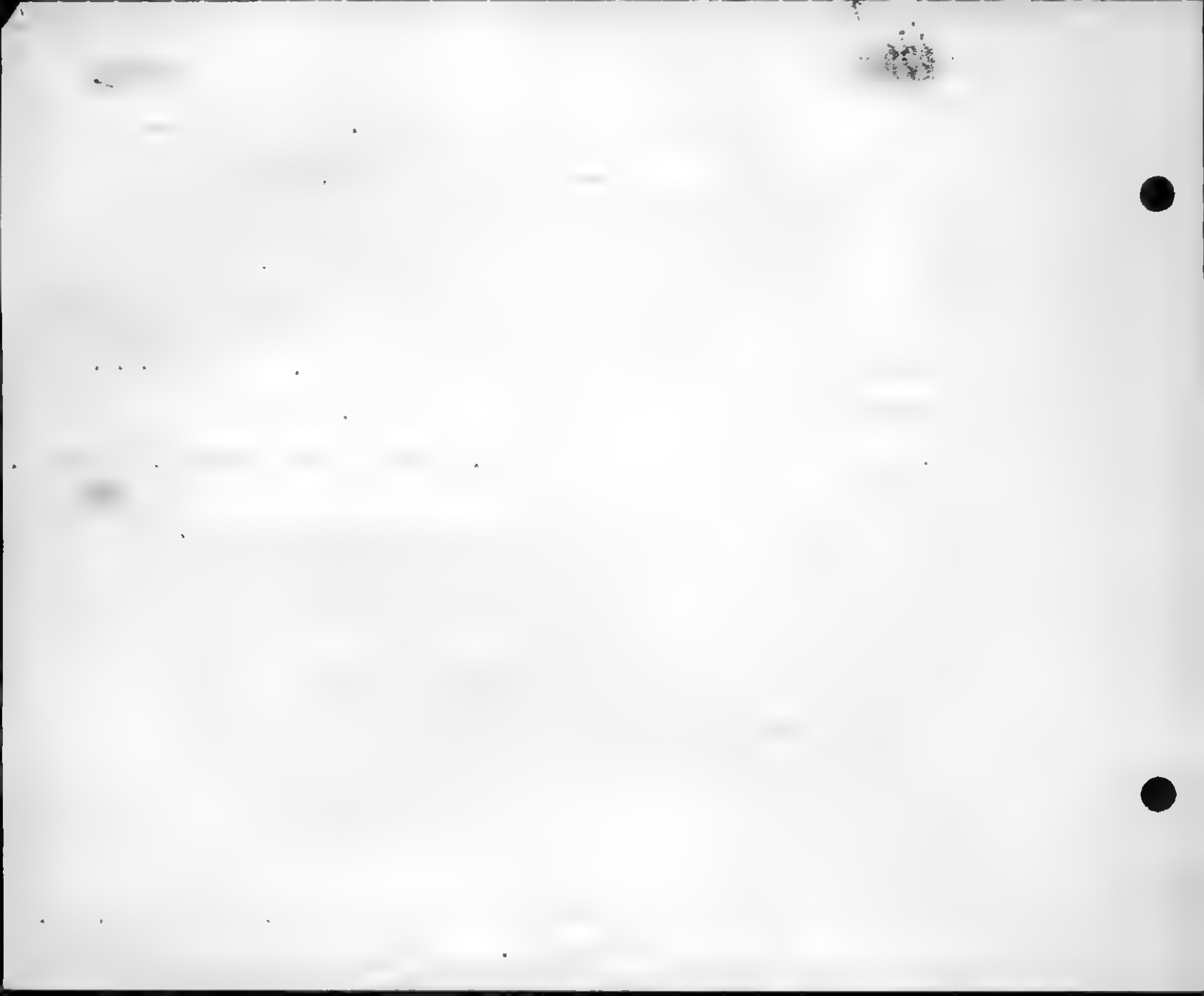
04268

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Copies may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Md.	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural, Cascade		c LENGTH OF STAY IN 1b 1 Week	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Shirley Viola Bowman		4. DATE OF DEATH March 6 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/35
9. AGE (In years last birthday) 32 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Machine Operator		11. BIRTHPLACE (State or foreign country) Smithsburg Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marshall Bowman	
14. MOTHER'S MAIDEN NAME Mary F. Brown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marshall Bowman, Route #1, Cascade Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exposure 732.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prolonged illness due to (c) Prolonged illness due to		19. INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fainted away from home into Mountain area - apparently succumbed to elements	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Unknown,		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Mountain Area nr. Ft. Ritchie Wash. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Edward W. Ditto III, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 3-11-67	
Address (Street, City, County or State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/67	
23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City or Town) (County) (State) Lantz #1, Frederick Co., Md.	
24. FUNERAL DIRECTOR Walter V. Grove		ADDRESS Waynesboro Pa.	
25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

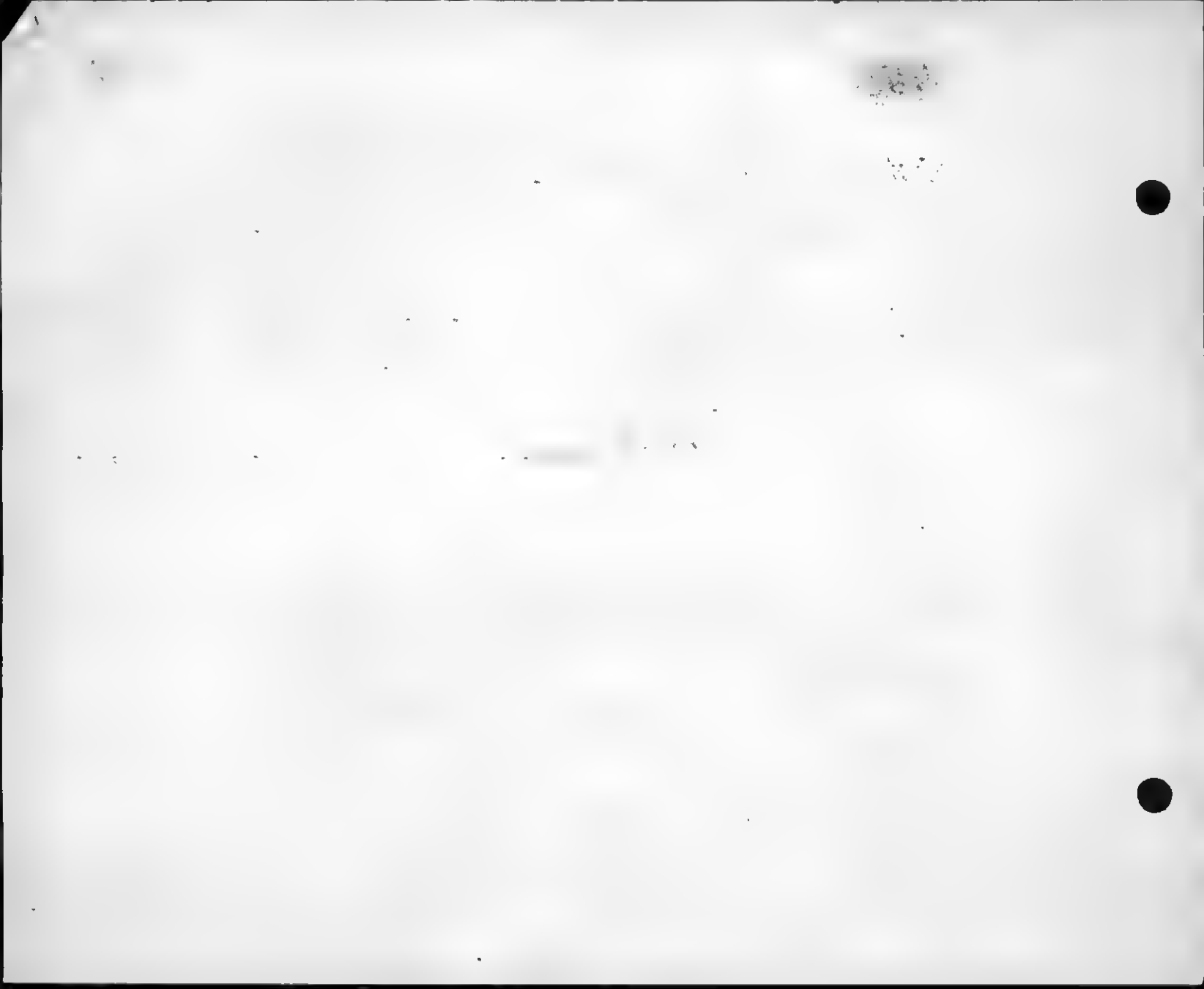
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04267

## CERTIFICATE OF DEATH

04269

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Martin Manor Rest Home</u>		d. STREET ADDRESS <u>16 Avalon Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jessa</u> Middle <u>Pearl</u> Last <u>Brill</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1887</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Lincoln, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander P. Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Jessa Grady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>210-30-943A</u>	
17. INFORMANT <u>J. Brill</u>		Address <u>29 Redwood Dr. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma colon &amp; sigmoid</u> <u>1538</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>igial Metastasis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-21-</u> , 19 <u>66</u> , to <u>3-4-</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Feb 25</u> , 19 <u>67</u> , and that death occurred at <u>3:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Dittus III</u>		22b. DATE SIGNED <u>3-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Dittus III, MD</u>		22d. ADDRESS <u>217 W. Washington St. Hagerstown Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Hoot</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Rest Haven Funeral Chapel Hagerstown, Md.		DATE <u>MAR 7 1967</u>	





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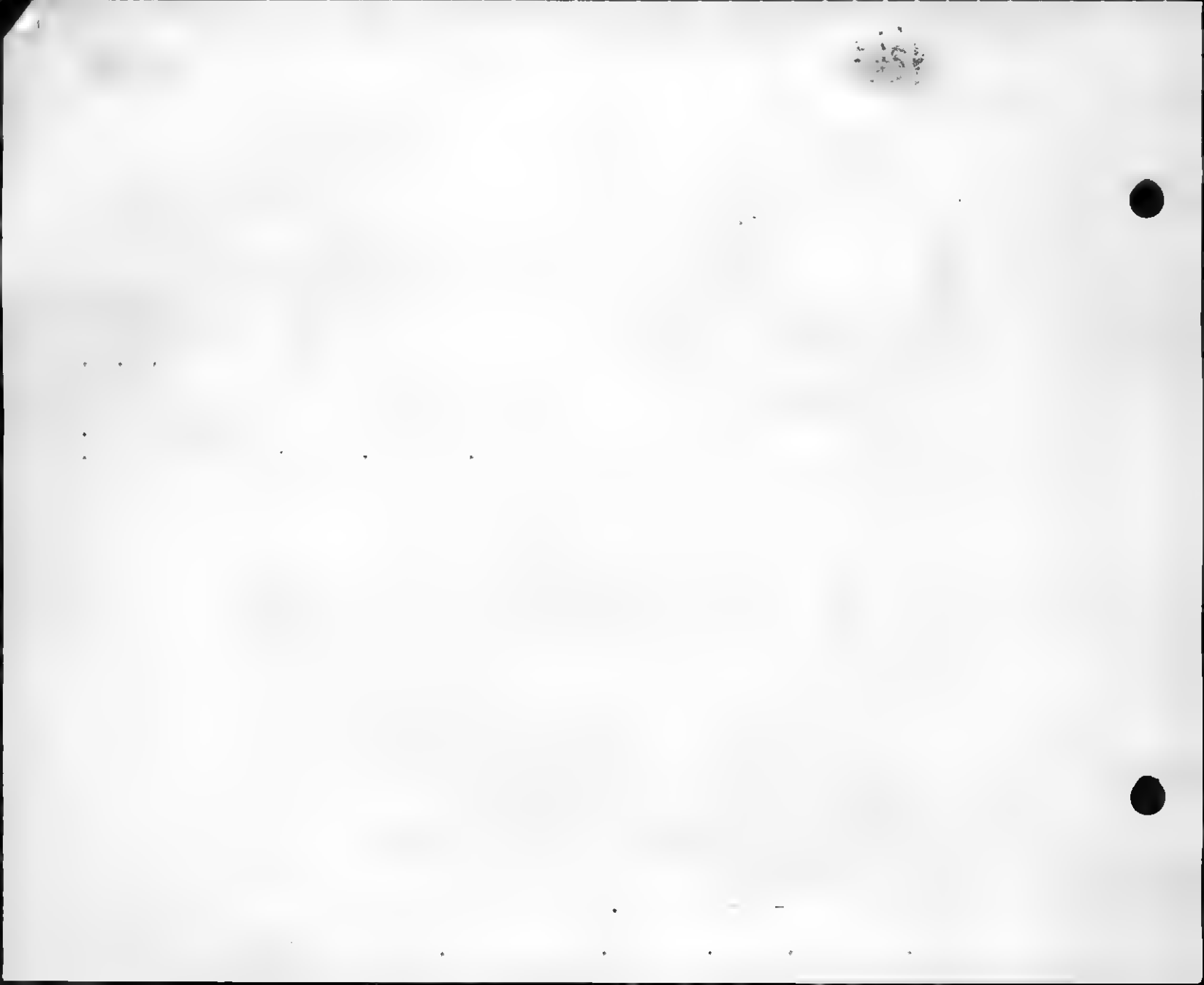
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04268

CERTIFICATE OF DEATH

04270

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>			c. LENGTH OF STAY IN <u>16</u> Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor, Inc.</u>				d. STREET ADDRESS <u>Holiday Acres, Box 262</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith Catherine Brown</u>				4. DATE OF DEATH Month Day Year <u>March 17, 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 16, 1893</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lansing, Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Charles Foerster</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sandowsky</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. James M. Archer 2131 Fairfax Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cerebral Vasc. Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 1966, to <u>March 17</u> , 1967, that (I) (we) last saw the deceased alive on <u>Mar 17</u> , 1967, and that death occurred at <u>4:15 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Lloyd A. Hoffner</u> M.D.				22b. DATE SIGNED <u>3/18/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffner</u>	
22d. ADDRESS <u>214 N. Pat. St. Hagerstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Lansing Michigan</u>	
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04269**

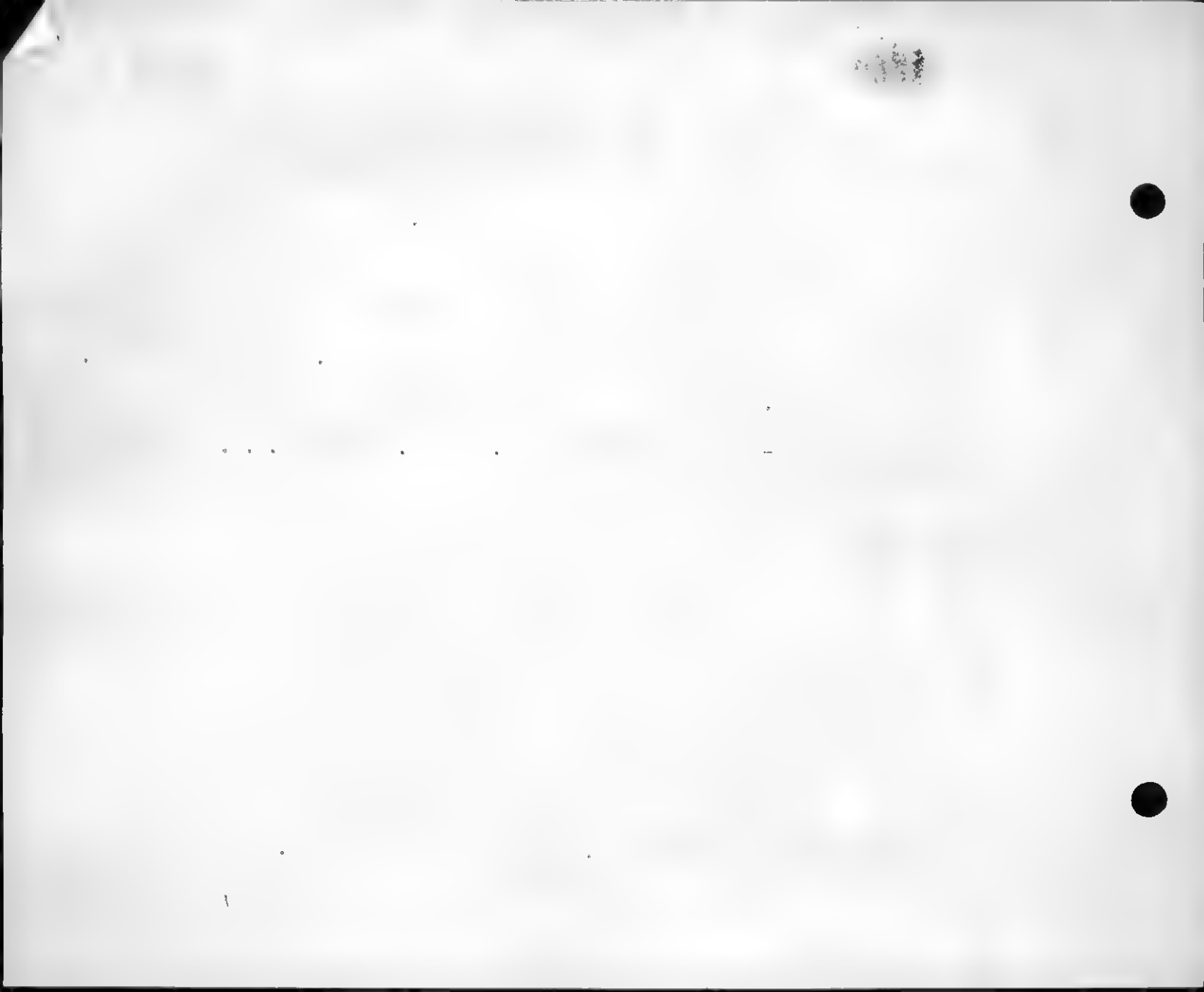
**CERTIFICATE OF DEATH**

**04271**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>		c. LENGTH OF STAY IN TB <b>5 YRS.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL FAYETTEVILLE</b>		d. STREET ADDRESS <b>R.D.# 3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>AVALON MANOR NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>SUELLA RINEHART CASPER</b>		4 DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1967</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>AUGUST 14, 1895</b>
9 AGE (In years last birthday) <b>71</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARTNER</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>ORCHARD</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDMUND P. COHILL</b>	
14. MOTHER'S MAIDEN NAME <b>MARY RINEHART</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16 SOCIAL SECURITY NO. <b>212-38-9683A</b>		17. INFORMANT <b>MR. JOHN P. CASPER</b> Address <b>FAYETTEVILLE PENNSYLVANIA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>2981 IMMEDIATE CAUSE (a) Myeloid metaplasia of spleen</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-9, 1962</b> , to <b>3-12, 1967</b> , that (I) (we) last saw the deceased alive on <b>3111 1967</b> , and that death occurred at <b>3:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John H. Hornbaker</b>		22b. DATE SIGNED <b>3-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. HORNBAKER M.D.</b>		22d. ADDRESS <b>154 W. WASH. ST. HAGERSTOWN, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MARCH 15, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOMEWOOD CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>PIITTSBURGH, PENNSYLVANIA</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		25a. REC'D BY REGISTRAR <b>WAK 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04270

CERTIFICATE OF DEATH

04272

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Knoxville</b> c. LENGTH OF STAY IN 1b <b>3 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Knoxville Rfd. 1</b> d. STREET ADDRESS <b>Weaverton</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elsie O. Castle</b>		4. DATE OF DEATH Month Day Year <b>March 31, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1906</b>
9. AGE (n years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min <b>9 26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Middletown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ira C. Moss</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Mae Cochran</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-26-8159</b>	
17. INFORMANT <b>Mr. Cornelius W. Castle, Jr. Rfd. 1</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>10 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-7-1963</b> to <b>1-9-1967</b> , that (I) (we) last saw the deceased alive on <b>1-9-1967</b> , and that death occurred at <b>4 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Secondari</b>		22b. DATE SIGNED <b>4-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>		22d. ADDRESS <b>Boonsboro Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brownsville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Brownsville, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25. REC'D BY REGISTRAR <b>APR 4 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

1954

1954



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

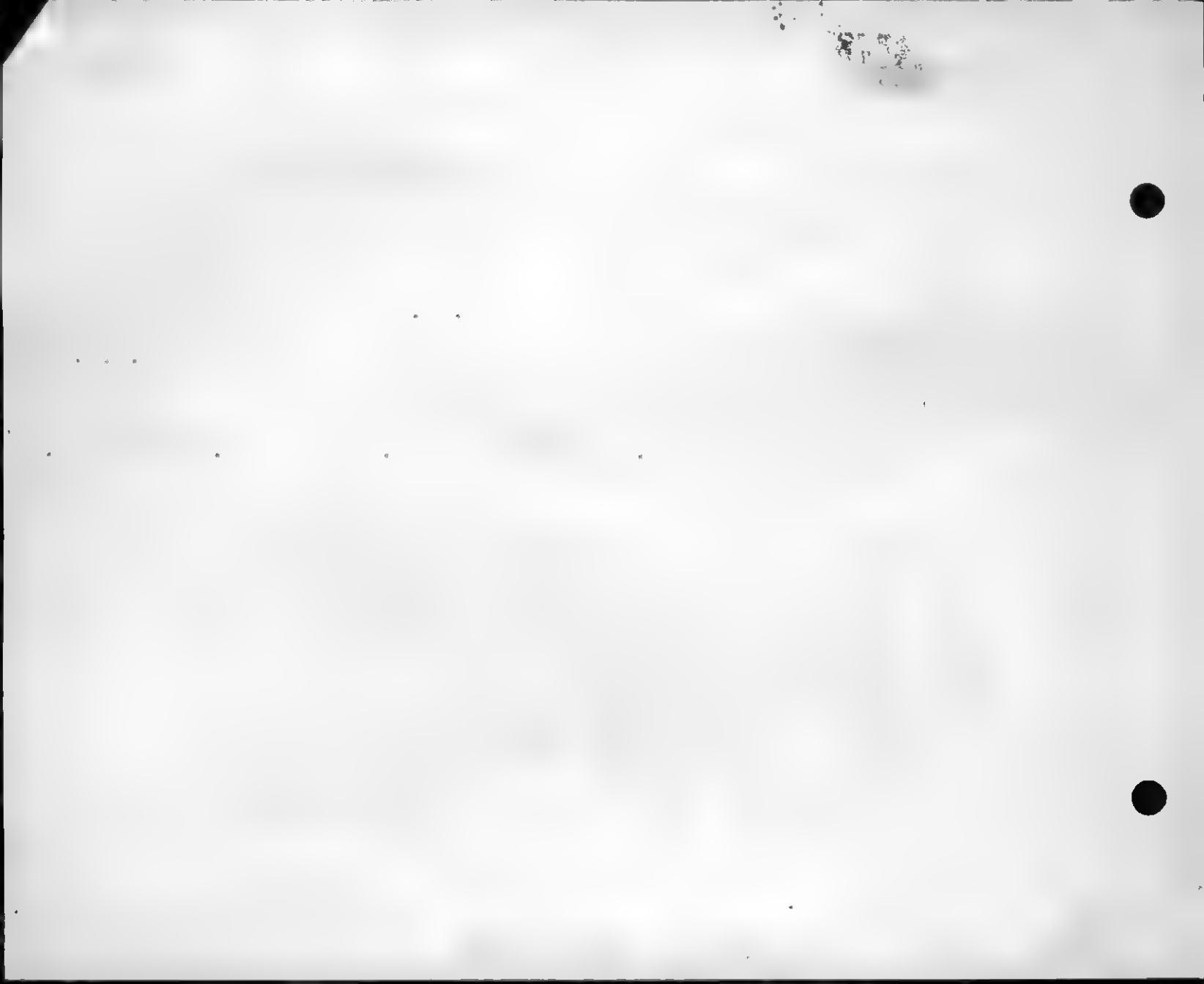
04271

04273

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAHERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>CHANEY</b> Last <b>CHANEY</b>		4. DATE OF DEATH Month <b>3</b> Day <b>25</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10.30.1904</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>25</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>CLEARSPRING MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM CHANEY</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN M POWELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>213.24.9699</b>	
17. INFORMANT <b>MARTIN VB. BOSTER</b>		Address <b>HAGERSTOWN MD. 34 W. FRANKLIN ST.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 4a/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>23 March 19 67</u> , to <u>death</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>25 March 19 67</u> , and that death occurred at <u>      </u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>John C. Stauff</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>27 March 67</u>
22c. PHYSICIAN'S NAME (Type) <u>John C. Stauff</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3.29.67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEMORIAL</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON MD.</b>
24. FUNERAL DIRECTOR <u>Howard J. Stone</u>		ADDRESS <u>Hagerstown Md</u>	25a. REC'D BY REGISTRAR <b>MAR 31 1967</b>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

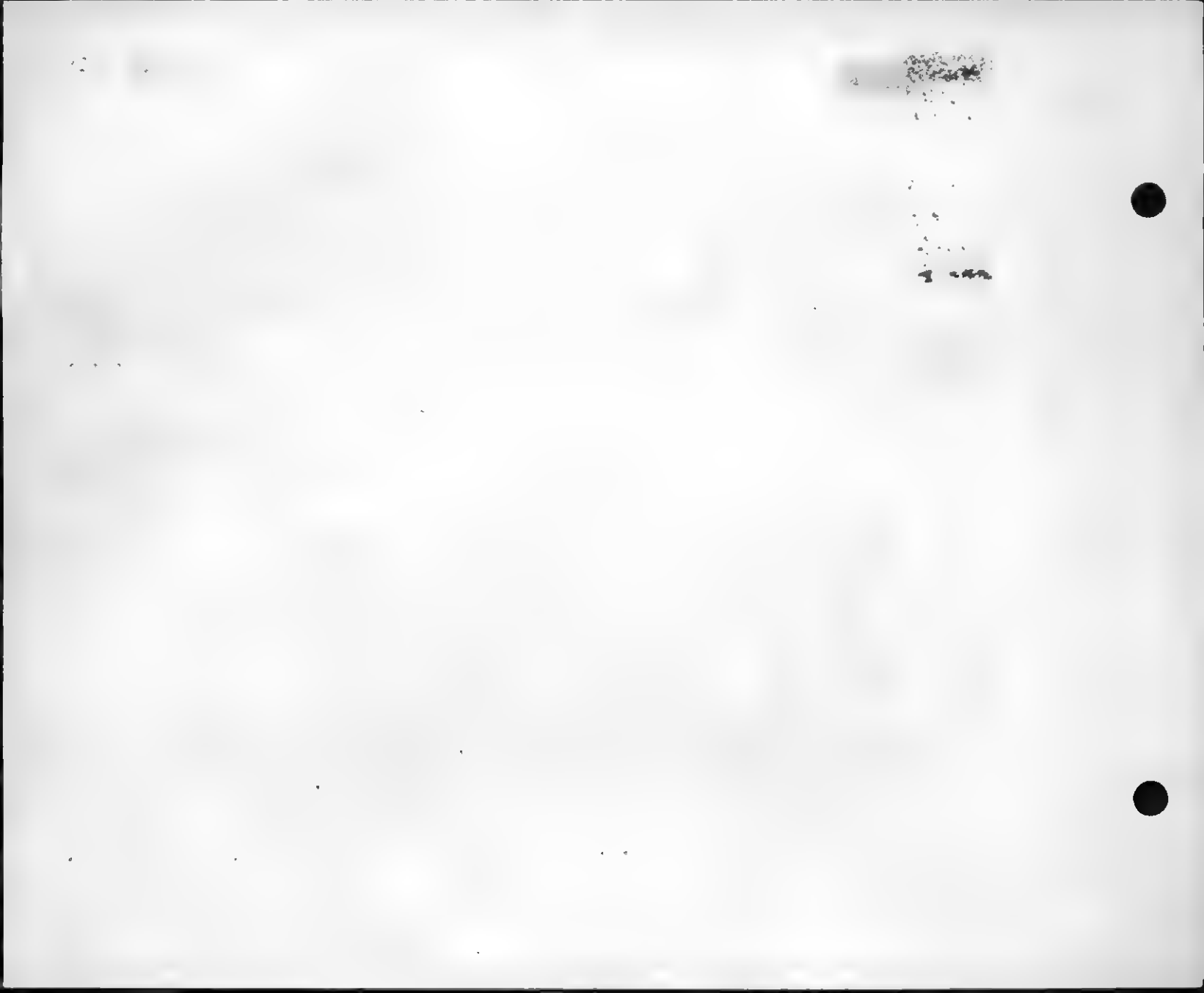
**CERTIFICATE OF DEATH**

**04272**

**04274**

<b>1 PLACE OF DEATH</b> a. COUNTY <b>WASHINGTON</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN b <b>70 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>733 MARYLAND AVENUE</b>				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institut an Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>733 MARYLAND AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>HARRY THOMAS CLARK</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>MARCH 24 19 67</b> Month Day Year				
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7 MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JULY 12 1874</b>	<b>9 AGE</b> (In years last birthday) <b>92 yrs</b>	<b>10 UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED MERCHANT</b>		<b>10b KIND OF BUSINESS OR INDUSTRY</b> <b>LIQUOR STORE</b>		<b>11 BIRTHPLACE</b> (County & State or foreign country) <b>PHILADELPHIA PENNSYLVANIA</b> <b>12 CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13 FATHER'S NAME</b> <b>THOMAS CLARK</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>CECILIA STOLER</b>				
<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		<b>16 SOCIAL SECURITY NO.</b> <b>214-09-9106A</b>		<b>17 INFORMANT</b> <b>957 VIEW STREET</b> <b>MRS MYRA L MARTIN HAGERSTOWN MARYLAND</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary occlusion</b> <b>7001</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b) Arteriosclerotic heart disease</b> <b>(c)</b> <b>INTERVAL BETWEEN DEATH AND DEATH</b> <b>Sudden</b> <b>Indefinite</b>					<b>19 WAS A JTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b> <b>20d INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b> <b>21. I certify that (I) (X) (initials) attended the deceased from Dec. 13, 19 63, to March 24, 19 67, that (I) (X) last saw the deceased alive on March 23, 19 67, and that death occurred at 12:15A. M, from causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>B.B. Kneisley</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>B.B. KNEISLEY M.D.</b> <b>22b. DATE SIGNED</b> <b>3/25/67</b> <b>22d ADDRESS</b> <b>148 W WASHINGTON ST, HAGERSTOWN MD.</b>							
<b>23a BURIAL, CREMATION REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>3/27/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ROSE HILL CEMETERY</b>			
<b>23d. LOCATION (City or Town) (County) (State)</b> <b>HAGERSTOWN WASHINGTON MD</b>		<b>24. FUNERAL DIRECTOR</b> <b>CHARLES M ROUZER HAGERSTOWN MARYLAND</b>					
<b>25a. REC'D BY REGISTRAR</b> <b>MAR 28 1967</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

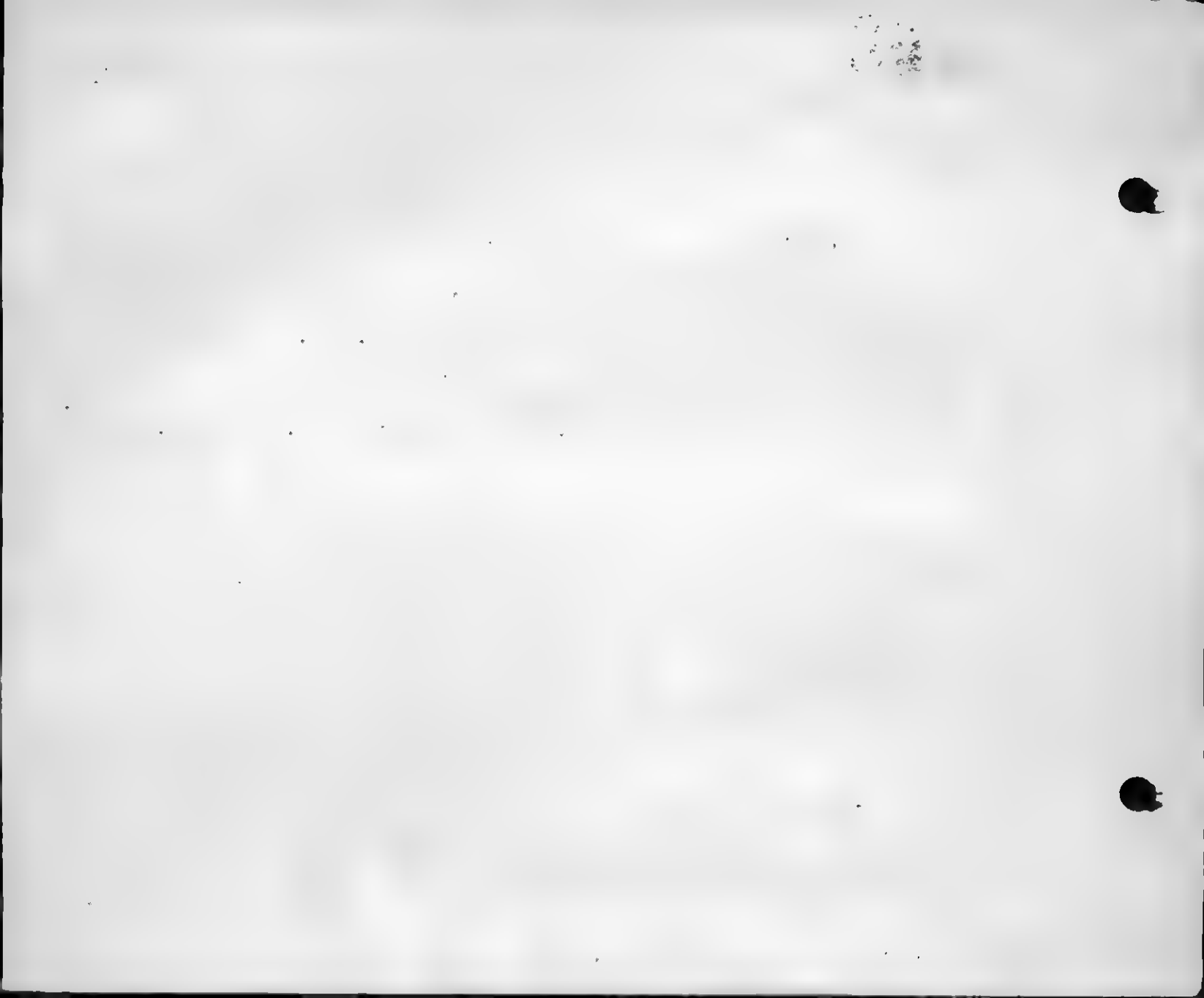
## CERTIFICATE OF DEATH

Reg. Dist. No. **04275****05273**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Convalescent Home</b>		d. STREET ADDRESS <b>45 N. Potomac St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Athalinda</b> Middle <b>Creager</b> Last <b>Creager</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 12, 1879</b>
9. AGE (In years last birthday) <b>87</b>		IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Creager</b>		14. MOTHER'S MAIDEN NAME <b>Bettie Kitzmiller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>A. Pauline Stoner, 304 S. Church St., Waynesboro Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive failure and pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>arterosclerotic heart disease</b> DUE TO (c) <b>4200</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>July</b> , 1964, to <b>March</b> , 1967, that I last saw the deceased alive on <b>3/8/67</b> , 19, and that death occurred at <b>8:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>580 Northern Avenue</b> DATE SIGNED ACTUAL SIGNATURE <b>Howard N. Weeks</b> M.D. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b> <b>Hagerstown, Maryland</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>3/13/1967</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Waynesboro Penna.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Martin Roe</b> ADDRESS <b>Waynesboro, Penna.</b> 24a. REC'D BY REGISTRAR <b>MAR 14 1967</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director; page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

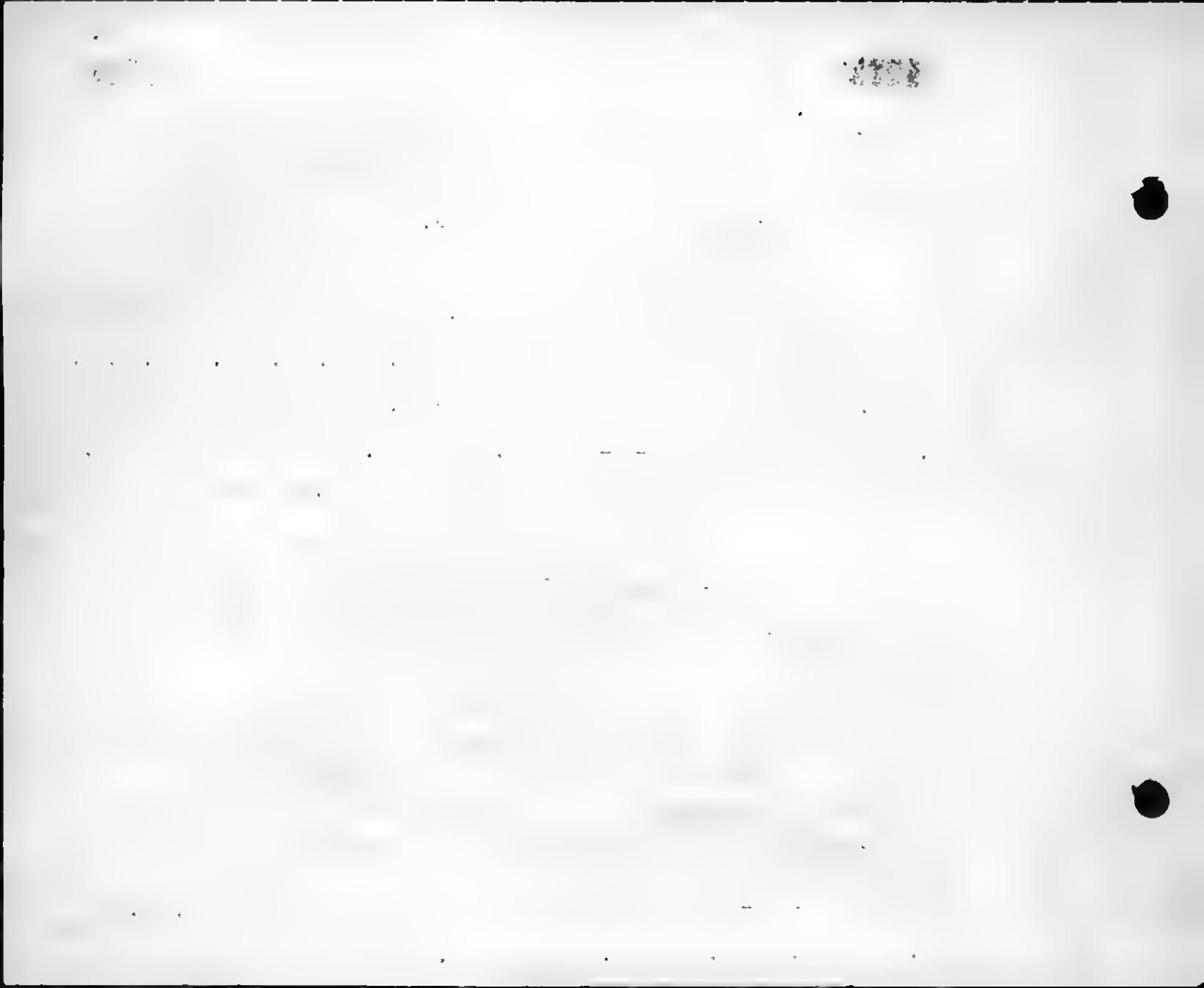
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04274

CERTIFICATE OF DEATH

04276

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY in lb <b>2 Weeks</b>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>			d. STREET ADDRESS <b>Rfd. 1</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Iona Katherine Greager</b>			4. DATE OF DEATH Month Day Year <b>March 23, 19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1922</b>		9. AGE (In years last birthday) <b>44 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>San Mar, Wash. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Perry O. Green</b>			14. MOTHER'S MAIDEN NAME <b>Cora M. Harrison</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>219-12-1127</b>	17. INFORMANT Address <b>Mr. Charles W. Greager, Boonsboro Rfd. 1, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of cervix &amp; metastases</b> <b>171X</b> DUE TO (b) <b>Leukemia due to obstructive jaundice</b> DUE TO (c) <b>Hypertensive C. V. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH <b>see 1965</b> <b>March 9-67</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Assema</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 11 - 1967</b> , to <b>March 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-22 19 67</b> and that death occurred at <b>4:55 AM</b> , from causes and on the date stated above					
22a. SIGNATURE <b>Sidney H. Kovenstein</b>			22b. DATE SIGNED <b>3-23-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY KOVENSTEIN</b>			22d. ADDRESS <b>FUNKSTOWN MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-25-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Myersville EUB. Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Myersville, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 28 1967</b>		



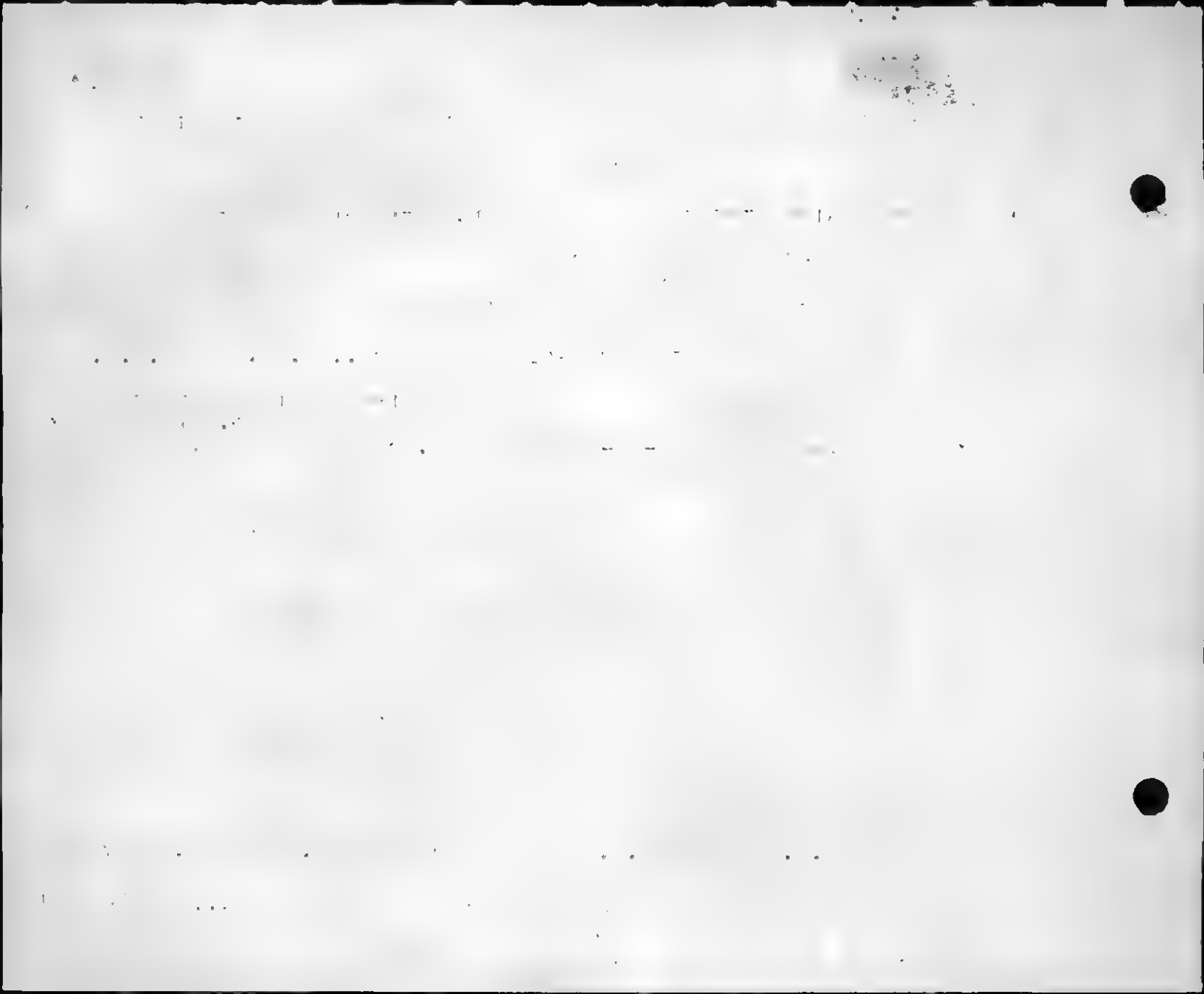
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**04275** **CERTIFICATE OF DEATH** **04277**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b> c. LENGTH OF STAY IN 1b <b>38 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>136 WEST HIGH STREET</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b> d. STREET ADDRESS <b>136 WEST HIGH STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>PRESTON ELWOOD CROUSE</b>				4. DATE OF DEATH Month Day Year <b>MARCH 7, 1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/17/1899</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>MORGAN CO., W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PETROLEUM SALES</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PETROLEUM SALES</b>			
13. FATHER'S NAME <b>ASBURY HOUSTON CROUSE</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE VIRGINIA SOTTLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES W.W. 1</b>				16. SOCIAL SECURITY NO. <b>212-03-8595</b>		17. INFORMANT <b>136 W. HIGH STREET</b> <b>ETHEL O. CROUSE HANCOCK, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO (b) <b>Pulmonary Edema</b> DUE TO (c) <b>?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/7, 1967</b> to <b>12/7, 1967</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>L.M. Shaffer</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>L.M. SHAFFER M.D.</b>	
22d. ADDRESS <b>MAIN STREET, HANCOCK, MARYLAND</b>		22e. ATTENDING PHYS. <input type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/>		22g. STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/10/67</b>		23c. NAME OF CEMETERY OR CREMATOR <b>OAKLAND METHODIST</b>		23d. LOCATION (City, town or county) (State) <b>MORGAN CO., WEST VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>Howard J. ...</b>				25a. REC'D BY REGISTRAR <b>MAR 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

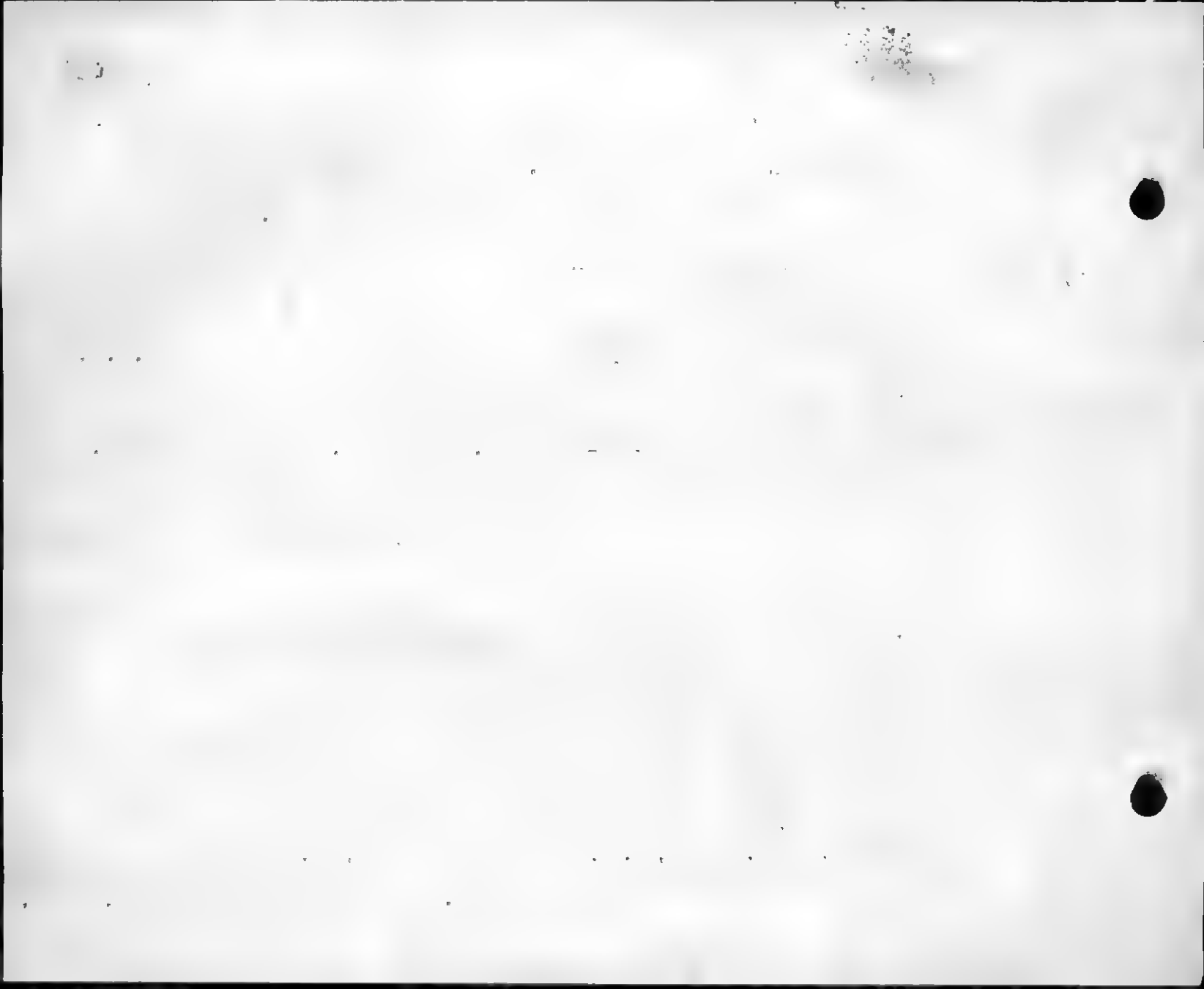
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04276

CERTIFICATE OF DEATH

04278

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN TB <b>45 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>			d. STREET ADDRESS <b>200B HAYES AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ELIZABETH</b> Last <b>CUSTER</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> Year <b>1967</b>		
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>6/20/1894</b>	9 AGE (In years first birthday) yrs <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11 BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>MORGAN PRICE</b>		
14. MOTHER'S MAIDEN NAME <b>SUAN BREEDEN</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>214-09-1133</b>		17 INFORMANT <b>MR. JOSEPH W. CUSTER</b>		18. HAGERSTOWN MD.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Indefinite</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous stroke cerebral accident Diabetes</b>					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-26</b> , 19 <b>49</b> , to <b>death</b> , 19 <b>67</b> , and that death occurred at <b>1:30 PM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Robert F. Keadle</b> M.D.		22b. DATE SIGNED <b>3-24-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert F. Keadle, M. D.</b>	
22d. ADDRESS <b>Hagerstown, Md. 21740</b>		22e. REC'D BY REGISTRAR <b>MAR 29 1967</b>			
22f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		22g. REGISTRAR'S NAME <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE THEREOF <b>3/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	
23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>		23e. NAME OF CEMETERY OR CREMATORY <b>HAGERSTOWN WASH. MD.</b>			
24. FUNERAL DIRECTOR <b>W. J. Normant, Hagerstown, Md.</b>					





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

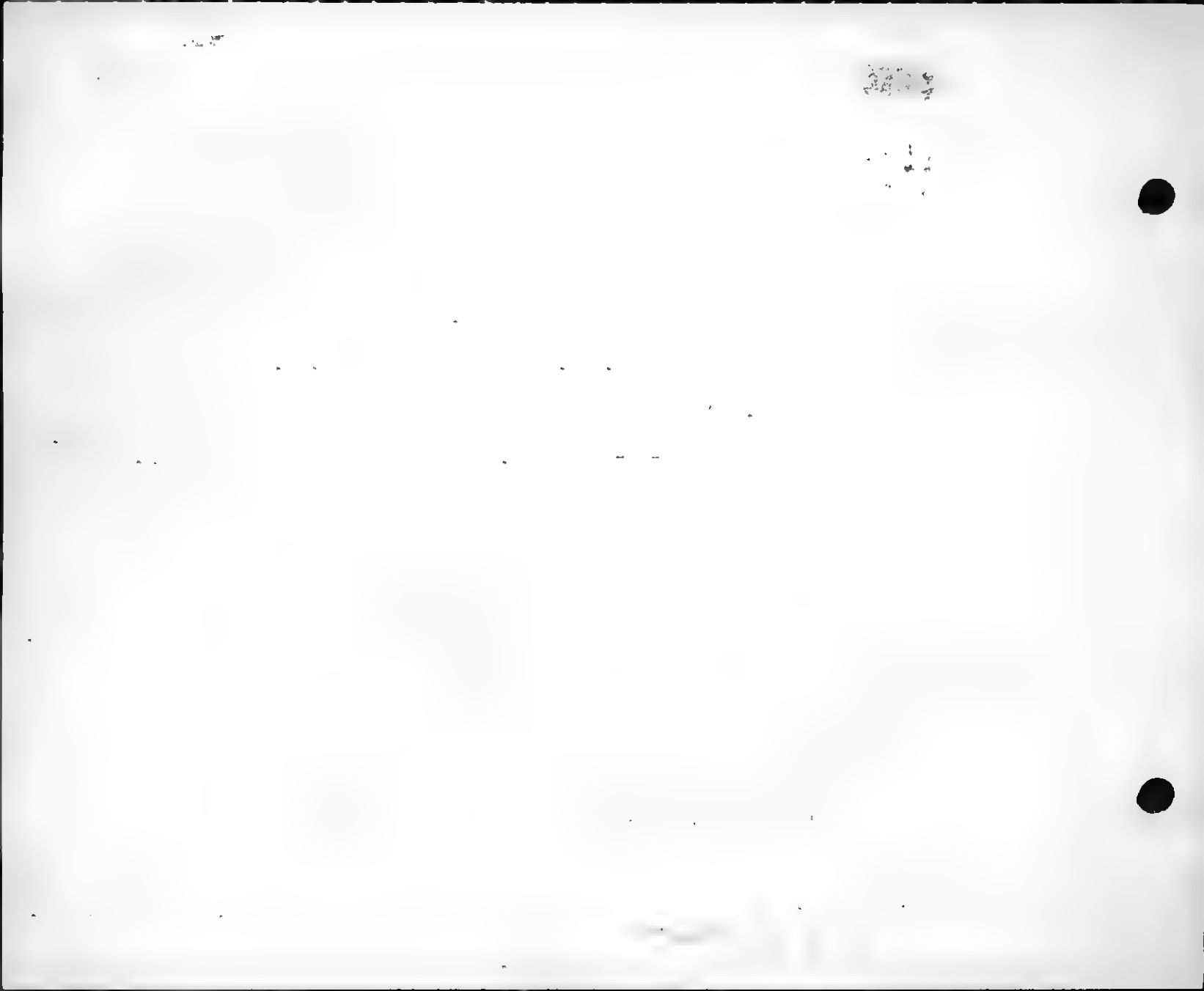
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04277

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04279

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN life <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1719 Homewood Road</u>				d. STREET ADDRESS <u>1719 Homewood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Francis</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>19 67</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1904</u>	9. AGE (In years last birthday) <u>62</u> yrs	10. UNDER 1 YEAR Months <u></u> Days <u></u>	11. UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dust Col. Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John R. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Huffer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-09-6138</u>		17. INFORMANT <u>Mrs. Goldie Davis</u>		Address <u>1719 Homewood Rd. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO (b) <u>athrosclerotic coronary artery disease</u> years Conditions (any which gave rise to immediate cause (a), stating the underlying cause last.) DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		Address (Street, city, town, or county) <u>580 Northern Ave. Hagerstown, Md.</u>		3/28/67 22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Harst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>DAMAR 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04278

CERTIFICATE OF DEATH

04280

1 PLACE OF DEATH a COUNTY <b>WASHINGTON</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c LENGTH OF STAY IN TB <b>45 YRS.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>			d STREET ADDRESS <b>335 S. CANNON AVENUE</b>		
3 NAME OF DECEASED (Type or print) First <b>ALFREDO</b> Middle <b>N.M.N.</b> Last <b>DeFELICE</b>			4 DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>19 67</b>		
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 29, 1899</b>	9 AGE (in years last birthday) <b>67</b> yrs	10 IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b> Hours <b>67</b> Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TURBINE TENDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT PLANT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ITALY</b>	
13 FATHER'S NAME <b>JOSEPH DeFELICE</b>			14. MOTHER'S MAIDEN NAME <b>GIUANNA</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>213-10-6785</b>		17 INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. EVA DeFELICE 335 S. CANNON AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Biliary Pancreatitis</b> 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Ruptured gall Bladder</b> DUE TO (c) <b>3 day</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour: a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/12</b> , 19 <b>62</b> to <b>3/9/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/9/67</b> , 19 <b>67</b> , and that death occurred at <b>7:50 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Lawrence L. Packer, Jr.</b> M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3/10/67</b>
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE L. PACKER, JR. M.D.</b>			22d. ADDRESS <b>145 W. WASHINGTON ST. HAGERSTOWN, MD.</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>MARCH 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>			25a. REC'D BY REGISTRAR DATE <b>MAR 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>

1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

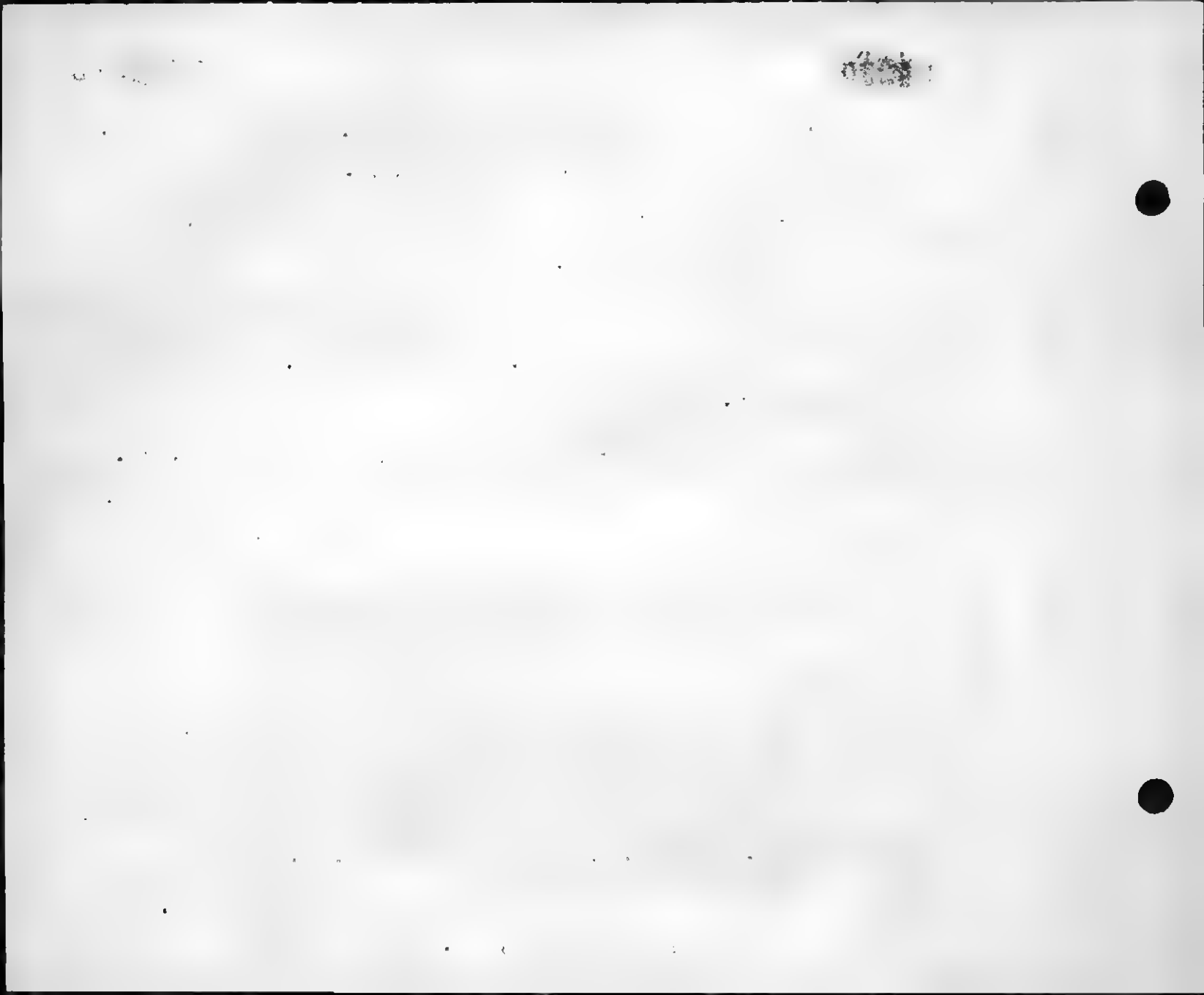
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04279

CERTIFICATE OF DEATH

04281

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Calvin</b> Last <b>Deibert</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1901</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>fireman</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>furniture Mfg.</b>	
12. BIRTHPLACE (County & State or foreign country) <b>Cavetown, Md.</b>		13. CITIZEN OF WHAT COUNTRY?	
14. FATHER'S NAME <b>Hezekiah W. Deibert</b>		15. MOTHER'S MAIDEN NAME <b>Mary Ann Burger</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>214-09-7287</b>	
18. INFORMANT <b>Hazel Ecton, Hagerstown, Md.</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Essential</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>October 11, 1959</b> , to <b>death</b> , that (I) (we) last saw the deceased alive on <b>3-18</b> 1967, and that death occurred at <b>2:04 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert F. Keadle</b>		22b. DATE SIGNED <b>3-20-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert F. Keadle, M. D.</b>		22d. ADDRESS <b>Hagerstown, Md. 21740</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3-21-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cavetown Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cavetown, Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04280

CERTIFICATE OF DEATH

04282

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa.</u>	
c. LENGTH OF STAY IN 1b <u>3 Days</u>		d. STREET ADDRESS <u>36 W. Balto. St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Mem. Conv. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARTHA F. DETRICH</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/5/1868</u>
9. AGE (In years last birthday) <u>98</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel G. Hollinger</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Funk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mary E. Detrich</u>		Address <u>Greencastle, Pa.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <u>4221</u> IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> Several years DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>3-17</u> , 19 <u>67</u> , to <u>3-19</u> , 1967, that (I) (we) last saw the deceased alive on <u>3-19</u> , 19 <u>67</u> , and that death occurred at <u>5:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		22b. DATE SIGNED <u>3-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Greencastle Pa.</u>
24 FUNERAL DIRECTOR <u>A. E. Nimmich</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





FOR STATE  
HEALTH **AM**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

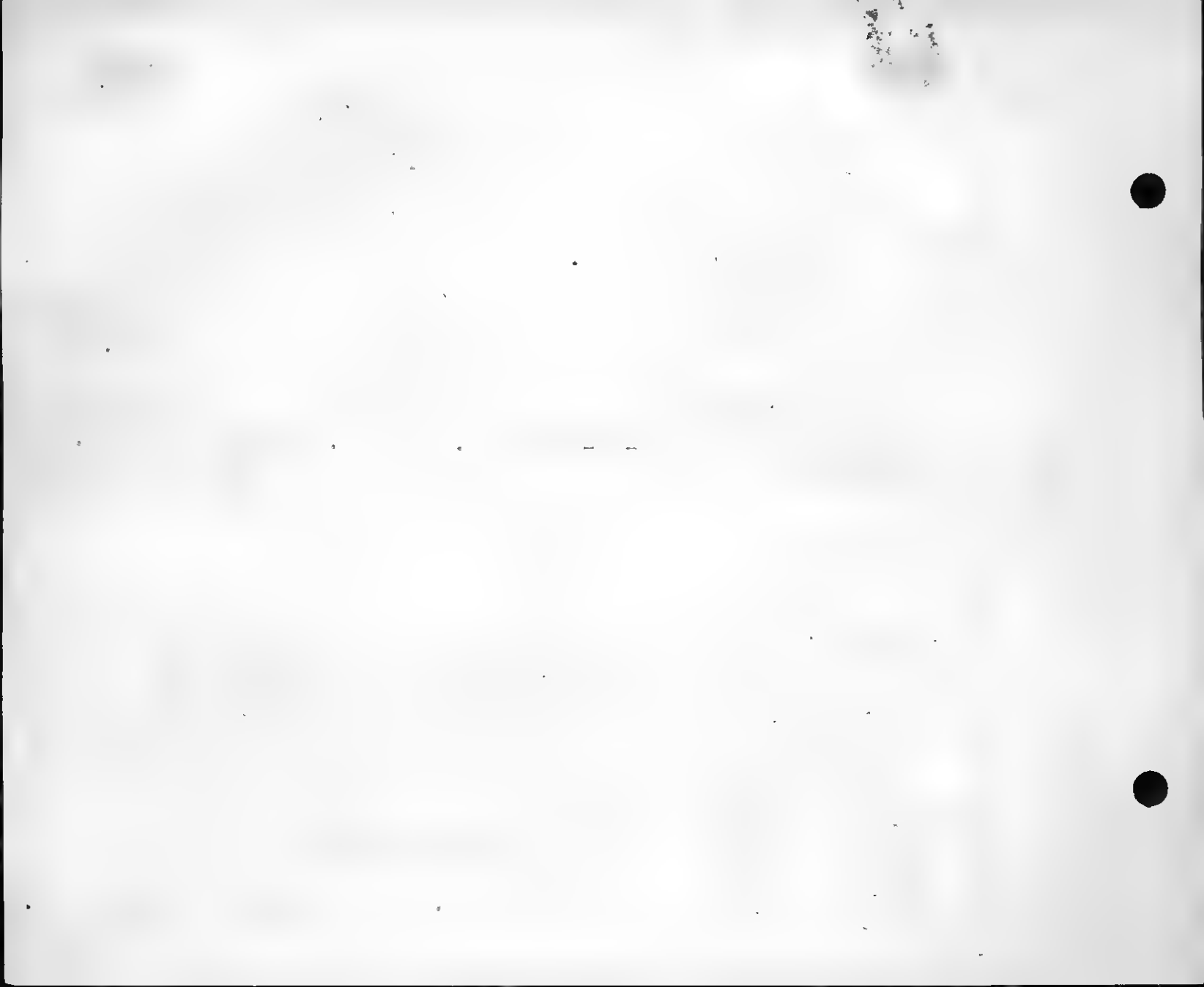
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04281

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04283

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY N. D. <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1212 W. WASHINGTON ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>M.</b> Last <b>DIETZ</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/5/1880</b>
9. AGE (In years lost & day) <b>86</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLAGGETT W. RANDALL</b>		14. MOTHER'S MAIDEN NAME <b>SARAH JOHNSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-9358A</b>	
17. INFORMANT <b>MR. HARRY C. RANDALL</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <b>9020</b> IMMEDIATE CAUSE (a) <b>Bronche pneumonia Secondary</b> DUE TO (b) <b>to Fracture of Femur</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fall when getting into bed at Home.</b>	
20c. TIME OF INJURY Month Day, Year <b>10<sup>th</sup> pm 10-30 1966</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) <b>Home</b>	20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Dittus III</b> M.D.		22. DATE SIGNED <b>3-11-67</b>	
EXAMINER'S NAME (Type) <b>Edward W. Dittus III</b>		Address (Street, City or Town, and County) <b>212 W. WASHINGTON ST. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/13/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>
24. FUNERAL DIRECTOR <b>W. J. Kerment</b>		25. RECD BY REGISTRAR <b>MAR 14 1967</b>	
ADDRESS <b>Hagerstown, Md.</b>		26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

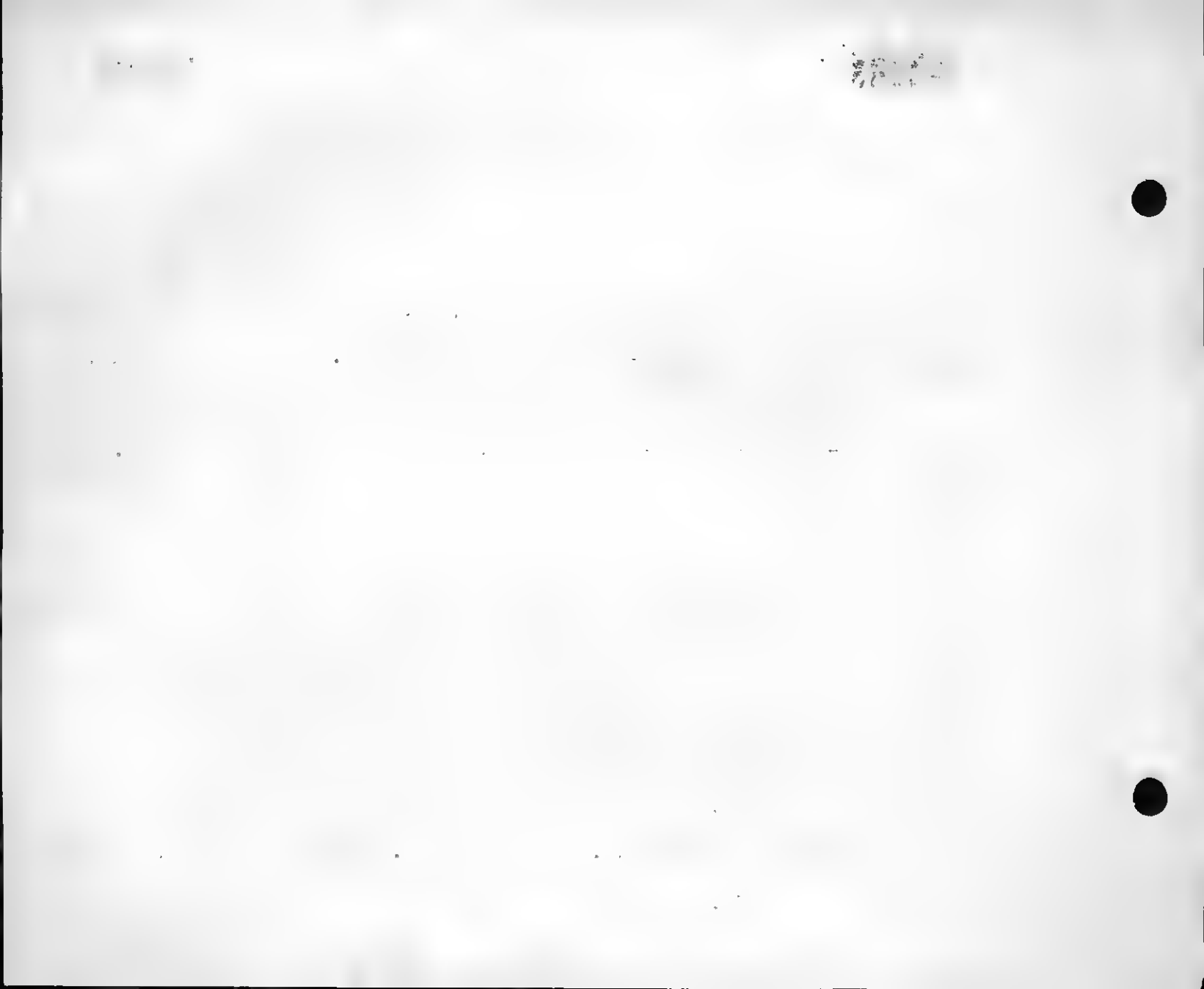
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04282

CERTIFICATE OF DEATH

04284

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN TB <b>65 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1707 OAK HILL AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CARL</b> Last <b>DITMER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 13, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SHEET METAL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND CO., PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD DITMER</b>		14. MOTHER'S MAIDEN NAME <b>EMMA KUNKLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>214-09-7381A</b>	
17. INFORMANT <b>MRS. WILMER MOSS</b>		<b>1707 OAK HILL AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma - frontal sinus</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>55</b> , to <b>Mar 10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Mar 10</b> , 19 <b>67</b> , and that death occurred at <b>6 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Lloyd A. Hoffman</b>		22b. DATE SIGNED <b>3/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LLOYD A. HOFFMAN M.D.</b>		22d. ADDRESS <b>214 N. POTOMAC STREET HAG., MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MARCH 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN MARYLAND</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1967</b>	
ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04283

04285

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>			d. STREET ADDRESS <b>61 NORTH AVENUE</b>		
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>GRACE</b> Last <b>DOWNIN</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>20</b> Year <b>19 67</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 9 1879</b>		9. AGE (In years last birthday) <b>87</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, MARYLAND</b>	
13. FATHER'S NAME <b>C GEORGE BORYER</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET GARMAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MARGARET B GAINES LAGUNA HILLS CALIF.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerosis - Gen.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>16 days</b> <b>Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 1939</b> to <b>Mar - 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar - 20 1967</b> , and that death occurred at <b>11:54 A.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Lloyd A. Hoffman</b> M.D.			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3/21/67</b>
22c. PHYSICIAN'S NAME (Type) <b>LLOYD A HOFFMAN M.D.</b>			22d. ADDRESS <b>214 N. POTOMAC ST. HAGERSTOWN MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON MD.</b>	
24. FUNERAL DIRECTOR <b>CHARLES M ROUZER HAGERSTOWN MARYLAND</b>			25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY Washington		Hagerstown		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN ID 3 Weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RFD2, Smithburg Md.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Agnes		First Virginia		Middle Draper		Last	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1905	
						9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Ira Grove				14. MOTHER'S MAIDEN NAME Anna Barbara Renner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James T. Draper Sr.		Address RFD2, Smithburg.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus, Massive						INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Thrombosis of Femoral and ilia <del>w</del> veins				2 days ?	
		DUE TO (c) Intracranial hemorrhage (intracerebral) with hemiplegia				5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension, Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 26, 1967, to March 29, 1967, that (I) (we) last saw the deceased alive on March 29, 1967, and that death occurred at 10:05 AM from the causes and on the date stated above.							
22a. SIGNATURE Archie Robert Cohen		22b. DATE SIGNED March 30, 1967					
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland 21722					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1, 67		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d. LOCATION (City, town or county) (State) Clear Spring, Maryland	
24. FUNERAL DIRECTOR Donald E. Thompson		ADDRESS Clear Spring,		25a. REC'D BY REGISTRAR APR 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

0003 0004



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

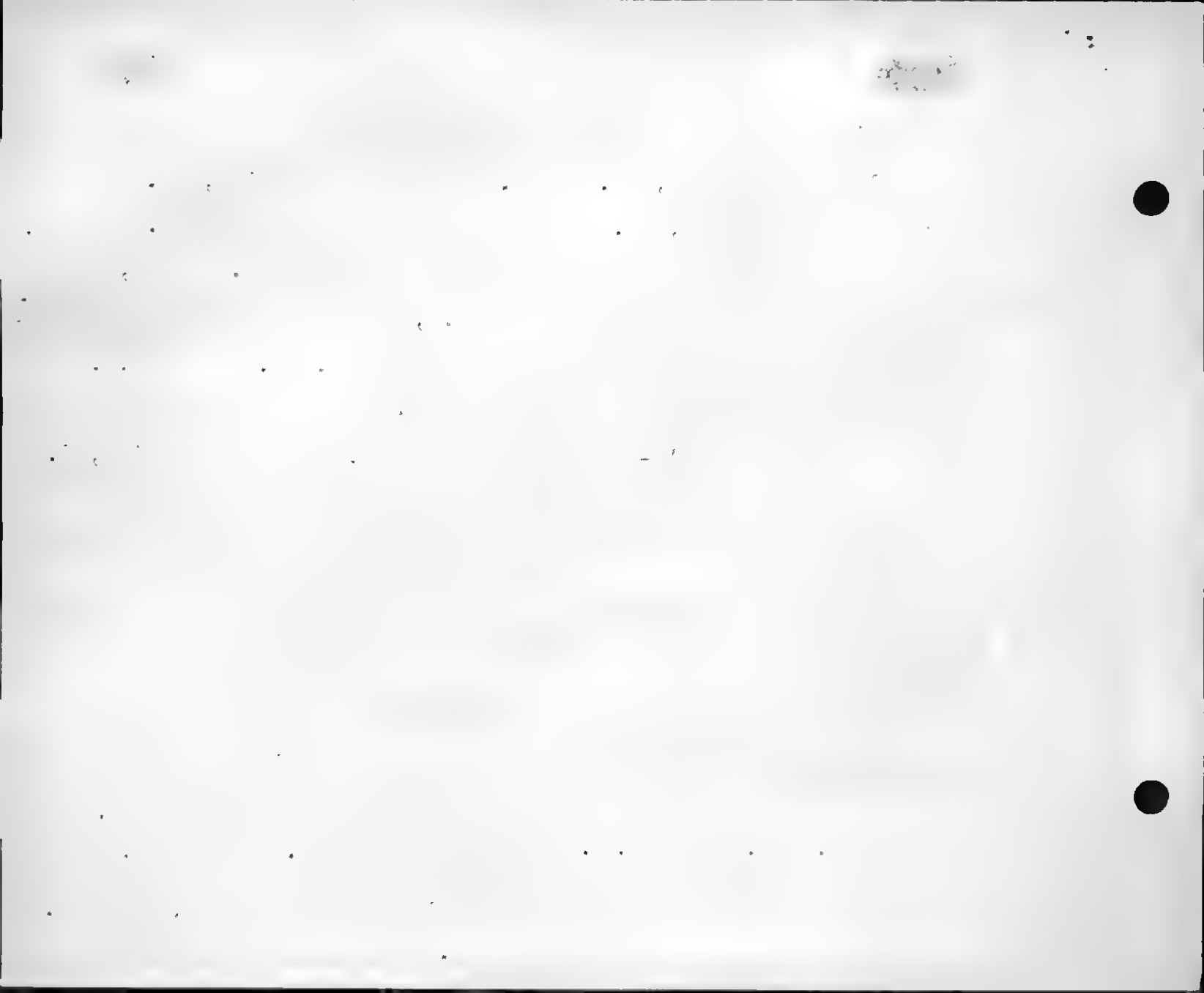
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04285

CERTIFICATE OF DEATH

04287

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Clear Spring, Md.</b>				c. LENGTH OF STAY IN 1b <b>8 Yrs.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural Clear Spring, Md.</b>				e. STREET ADDRESS <b>Rural Clear Spring, Md.</b>			
3. NAME OF DECEASED (Type or print) <b>Ignatious Samuel Drury</b>				4. DATE OF DEATH <b>Mar. 5, 1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1891</b>		9. AGE (In years last birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Franklin Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Luther Drury</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Britton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-01-8219</b>		17. INFORMANT <b>Mrs Annie Drury Clear Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4401 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) <b>10 yrs</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>11-2</b> , 1967, to <b>3-6</b> , 1967, that (1) (we) last saw the deceased alive on <b>2-20</b> , 1967, and that death occurred at <b>10:30M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Dr. M. E. Byrkit, M. D.</b>				22b. DATE SIGNED <b>March 6, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. M. E. Byrkit, M. D.</b>	
22d. ADDRESS <b>28 W Potomac St. Williamsport, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/8/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pinesburg Mennonite</b>		23d. LOCATION (City or Town) (County) (State) <b>Clear Spring, Md.</b>	
24. FUNERAL DIRECTOR <b>Margaret Rowland</b>				25a. REC'D BY REGISTRAR <b>MAR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

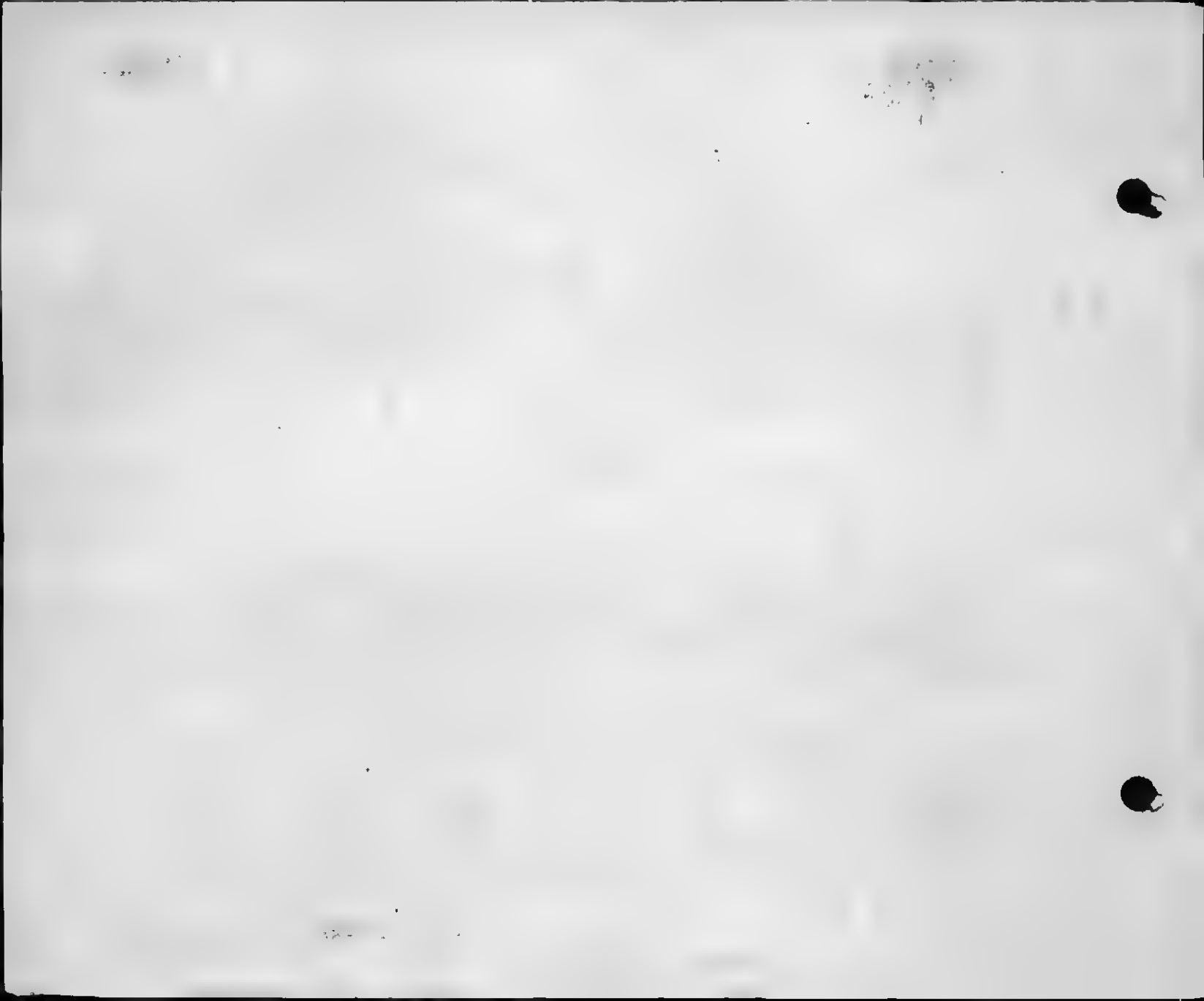
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

04286

04288

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Avalon Manor</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Chambersburg</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Newton</u> Middle <u>I</u> Last <u>Eshelman</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>8</u> Year <u>1967</u>															
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27, 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refuse collector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Isaac G. Eshelman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wolford</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>195-28-0445</u>				17. INFORMANT <u>Mrs Della R. Eshelman</u> Address <u>41 Chambersburg, Pa.</u>			
<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis - generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>1 yr. +</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II, of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____																			
<b>21. I certify that (I) (the hospital) attended the deceased from Feb. 19, 1967 to 3-8, 1967, that (I) (we) last saw the deceased alive on 3-8, 1967, and that death occurred at 12 M from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <u>Carl A. Hoffman</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Lloyd A. Hoffman</u> <b>22d. ADDRESS</b> <u>214 N. Potomac St. Hagerstown, Md</u>				<b>22b. DATE SIGNED</b> <u>3/11/67</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3/11/67</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fletcher Chapel Cemetery</u>				<b>23d. LOCATION (City, town, or county)</b> <u>Franklin Penna.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert R. Bachman</u> <u>Chambersburg, Pa.</u> <b>REGISTERED BY REGISTERAR</b> <u>Mar 14 1967</u> <b>REGISTERAR'S SIGNATURE</b> <u>William Judge</u>																			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

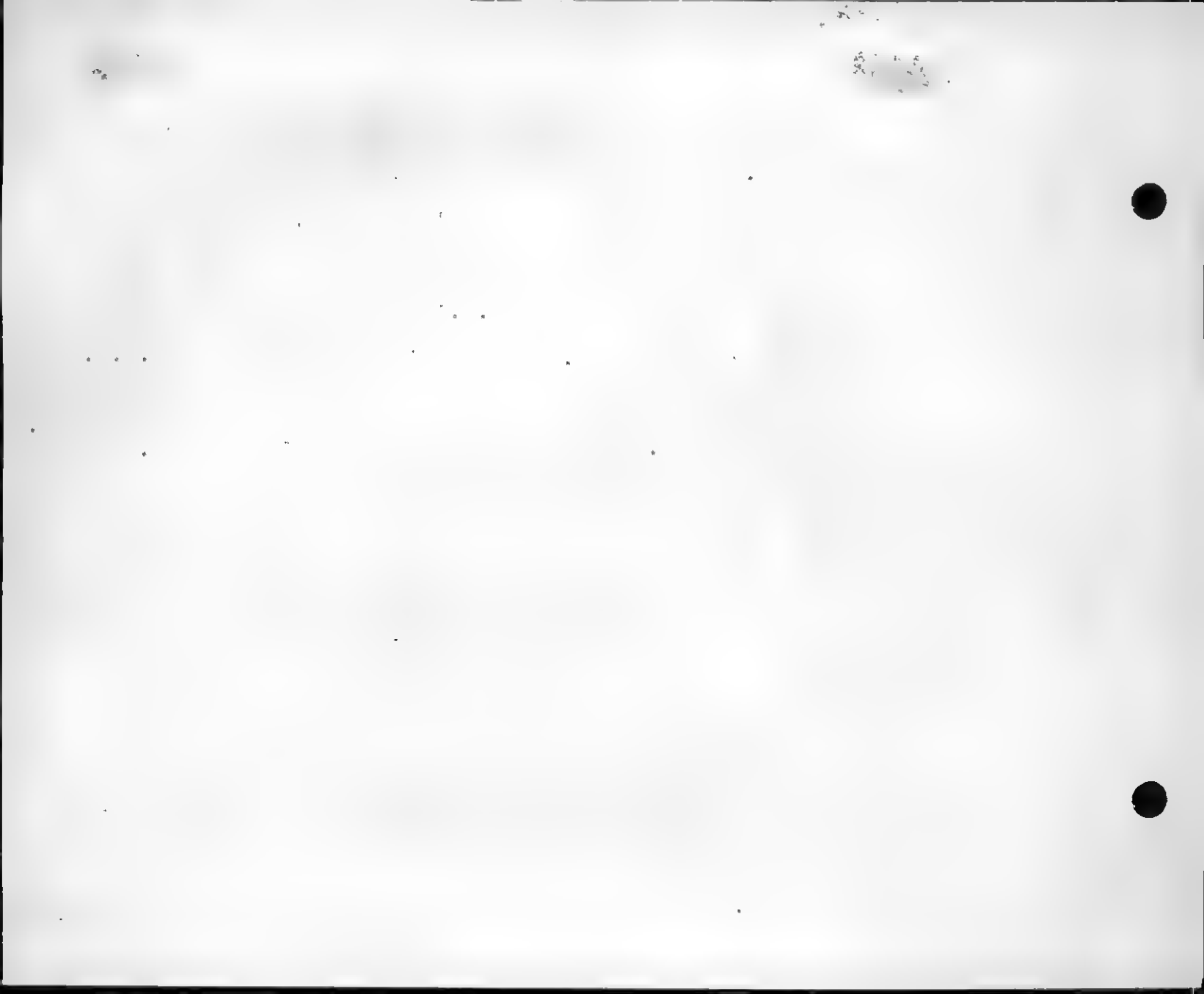
CERTIFICATE OF DEATH

04287

04289

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN MD.</b>		c. LENGTH OF STAY IN 1b <b>2 WKS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>WILLIAM</b> Last <b>FLOWERS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6.1.1900</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FORMAN, SOUTHERN PIPE LINE CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON COUNTY MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT FLOWERS</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE FISHER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>203.07.6454</b>	
17. INFORMANT <b>MARY M FLOWERS</b>		Address <b>217 DALE ST. HANCOCK MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>442X</b> <b>Arteriosclerosis</b> DUE TO <b>Nephrosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterioventricular Dis.</b> (c) <b>Hepatomagaly, Bronchitis, emphysema. ? Nephros.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>grs.</b> <b>grs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hepatomagaly, Bronchitis, emphysema. ? Nephros.</b>			
20a. ALL DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>27 Feb</b> , 19 <b>67</b> , to <b>10 Mar</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10 Mar</b> , 19 <b>67</b> , and that death occurred at <b>8 P.</b> M. from causes and on the date stated above.			
22a. SIGNATURE <b>Richard T. Binford</b> M.D.		22b. DATE SIGNED <b>13 Mar 67</b>	22c. PHYSICIAN'S NAME (Type) <b>Richard T. Binford, M. D.</b>
22d. ADDRESS <b>1135 Potomac Avenue Hagerstown, Md.</b>		22e. REC'D BY REGISTRAR <b>Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3.13.67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROGER HEIGHTS</b>	23d. LOCATION (City or Town) (County) (State) <b>RURAL HANCOCK WASHINGTON MD.</b>
24. FUNERAL DIRECTOR <b>Howard J. Stone Hancock, Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**M**  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (B)  
6M 1/67

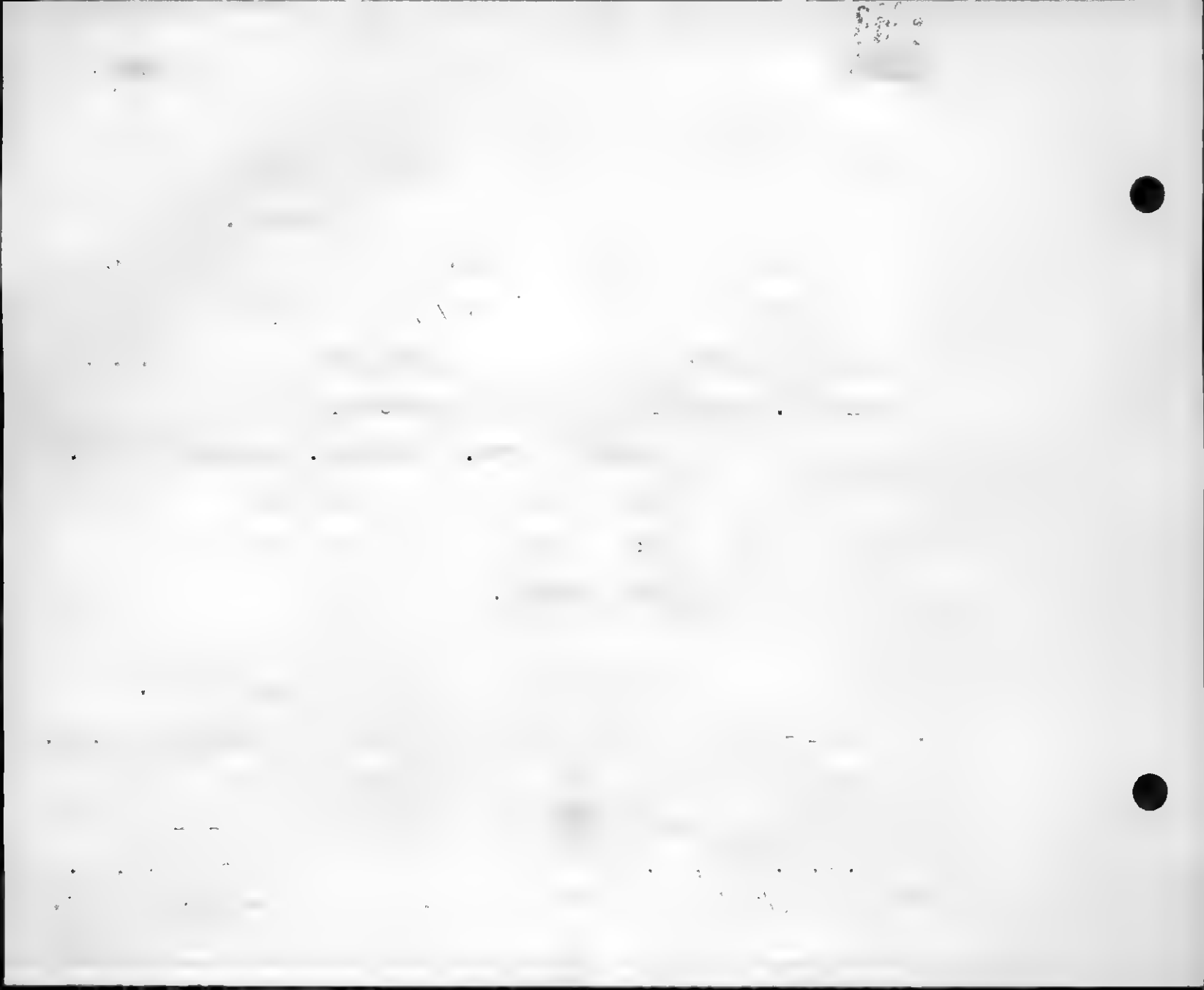
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04288

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04290

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN Ib <b>1 DAY</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>			d. STREET ADDRESS <b>31 E. CHURCH ST.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>EUGENIA MARIE GLADHILL</b>			4. DATE OF DEATH Month Day Year <b>MARCH 16 19 67</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12/3/1963</b>		9. AGE (In years last birthday) yrs. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>ROLLAND E. GLADHILL</b>			14. MOTHER'S MAIDEN NAME <b>PATRICA MEADE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. PATRICA M. GLADHILL MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Communicated Expressed Fracture Skull Left</b> 8104 DUE TO (b) <b>Parietal With Brain Laceration &amp; Intra-</b> DUE TO (c) <b>cranial Hemorrhage.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car which was in head on collision.</b>			
20c. TIME OF INJURY Month, Day Year Hour <b>3:05 pm</b> <b>3-16-19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State R# 68 Williamsport, Washington, Md.</b>	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>N. E. W. Ditto, Jr.</b>		M.D.		22. DATE SIGNED <b>3-17-67</b>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		Address (Street, city, town, or county) <b>Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, OR OTHER METHOD <b>BURIAL</b>	23b. DATE THEREOF <b>3/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEM. GARDENS</b>		23d. LOCATION (City or town) (County) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DAVID H 21 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



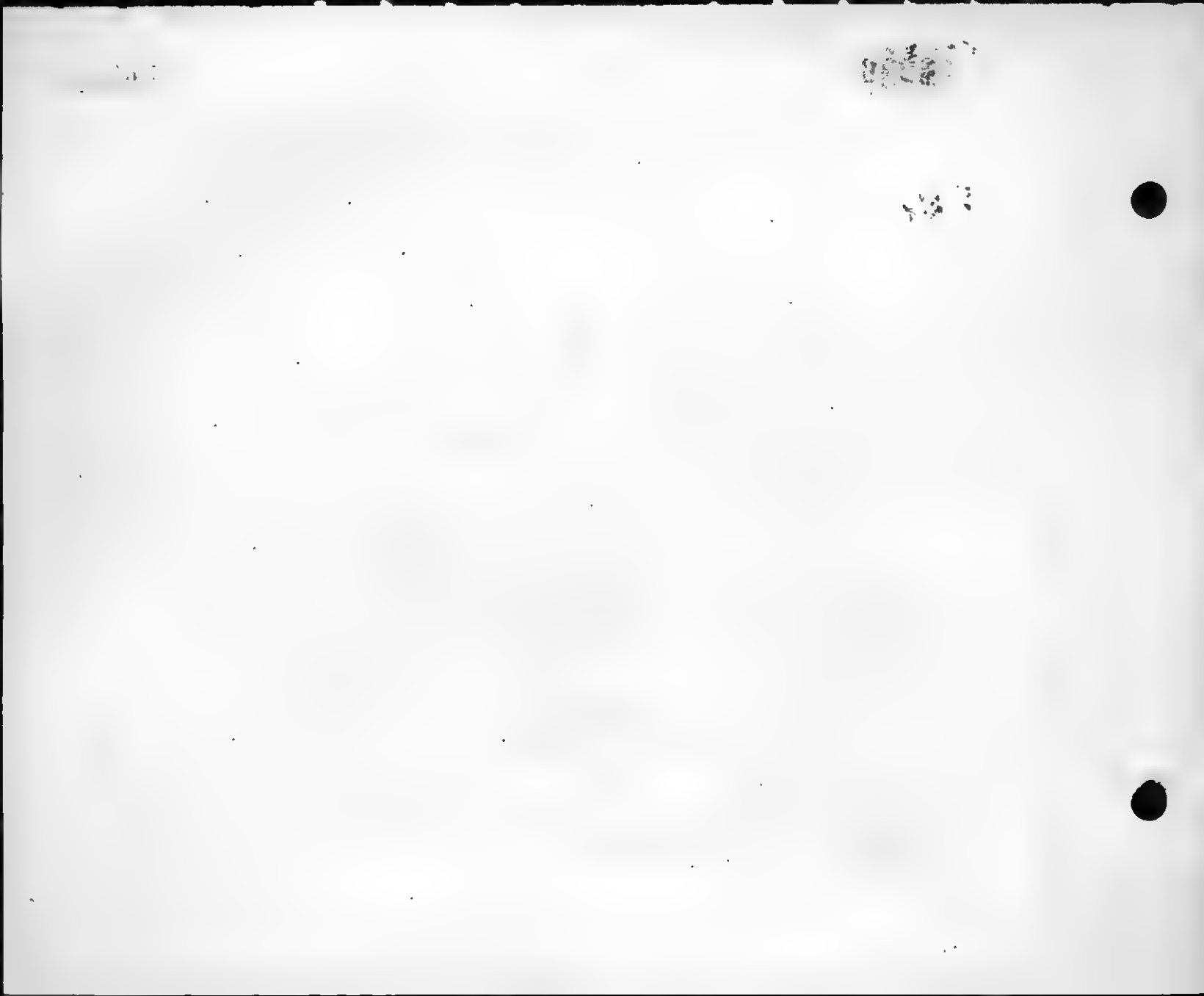


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY <b>Franklin</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Garlock Nursing Home</b>						d. STREET ADDRESS <b>30 Cottage Street,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>EDWARD</b>		Middle <b>GROSSNICKLE</b>		Last <b>GROSSNICKLE</b>		4. DATE OF DEATH Month <b>March</b>		Day <b>10,</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1, 1877</b>		9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Landis Tool Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Leonard Grossnickle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Renner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>		17. INFORMANT <b>Kenneth Grossnickle, Pennsylvania.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Arterio Sclerosis, generalized</b> DUE TO (c) <b>+ Arterio Sclerotic heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-4 - 1967</b> , to <b>3-10 - 1967</b> , that (I) (we) last saw the deceased alive on <b>3-4 - 1967</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Edward W. D. Hott, M.D.</b>						22b. DATE SIGNED <b>3-10-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Edward W. D. Hott, M.D.</b>		22d. ADDRESS <b>217 W. Washington St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/12/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Middletown, Fred. Co. Md.</b>		24. FUNERAL DIRECTOR <b>Gladhill Company, Middletown, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04290

CERTIFICATE OF DEATH

04292

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 5 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 17 Public Square	
3. NAME OF DECEASED (Type or print) BERTHA LORRAINE GUESSFORD		4. DATE OF DEATH March 26 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10 1902
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stitcher		10b. KIND OF BUSINESS OR INDUSTRY Shoe Co	
11. BIRTHPLACE (County & State, or foreign country) Parkersburg W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonidas Roane		14. MOTHER'S MAIDEN NAME Bessie (No Record)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-9180	
17. INFORMANT James R. Middlekauff		Address 210 Hager St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral embolus DUE TO Posterior coronary ischemia (b) Arterio sclerosis, generalized (c) Pneumonia, hepatic cirrhosis			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/21, 1967, to 3/26, 1967, that (I) (we) last saw the deceased alive on 3/25, 1967, and that death occurred at 6:45 AM, from causes and on the date stated above			
22a. SIGNATURE George Hennings		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George Hennings		22d. ADDRESS 315 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/28/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland
24. FUNERAL DIRECTOR K. Coffman Funeral Home Inc. Hagerstown, Maryland		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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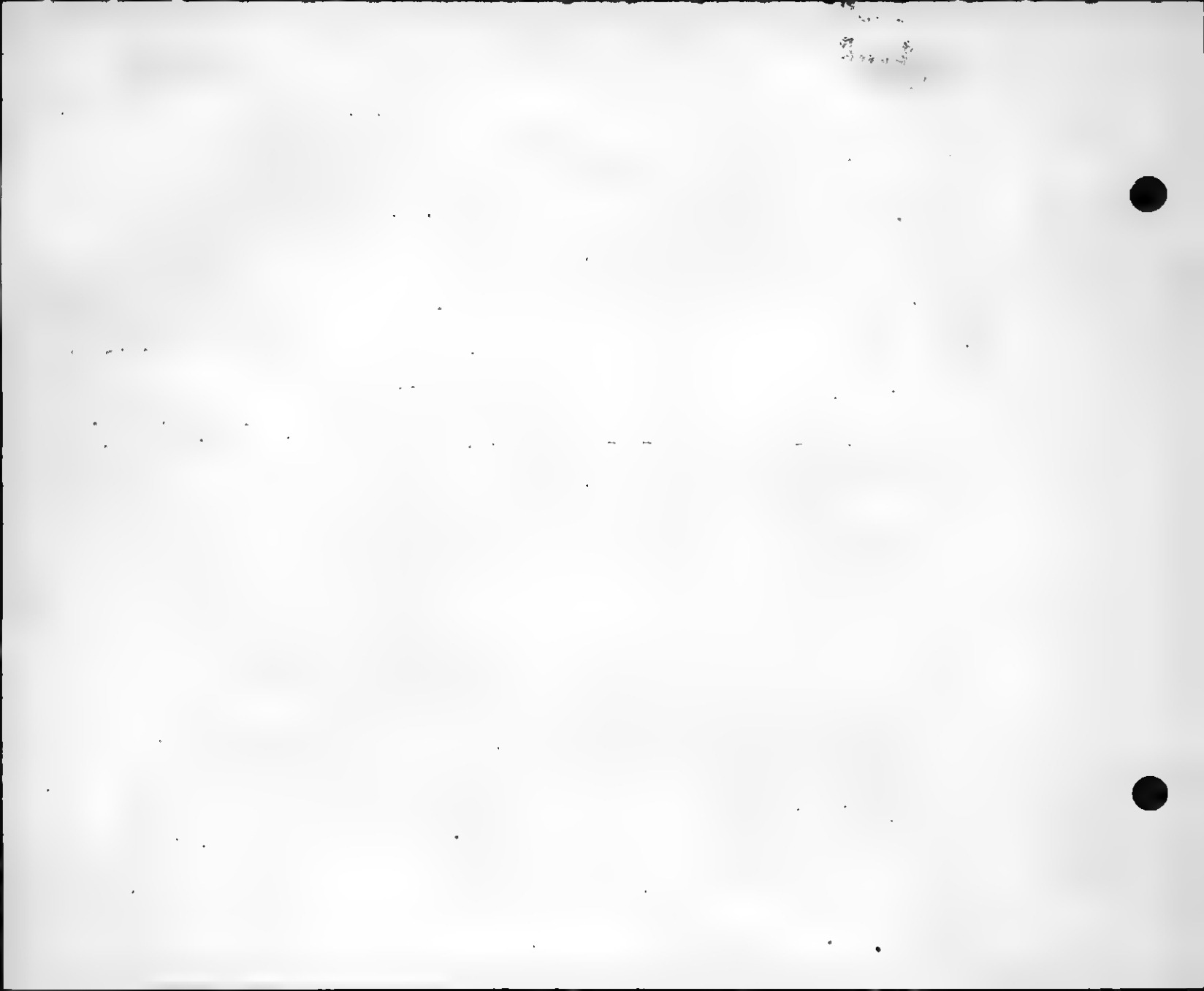
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04291						04293					
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 22 W. Potomac Street						d. STREET ADDRESS 22 W. Potomac Street					
3. NAME OF DECEASED (Type or print) David Mc Kendree Harsh			First Middle Last			4. DATE OF DEATH March 23 19 67			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb.. 24 1883		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender				10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (County & State, or foreign country) Williamsport Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME David H. Harsh						14. MOTHER'S MAIDEN NAME Malinda Wilson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-12-0501		17. INFORMANT Miss. Louise Harsh Williamsport Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Atherosclerosis (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) OUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none											
INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10 yrs											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1965, to 3-22 1967, that (II) (we) last saw the deceased alive on 3-23 1967, and that death occurred at 3:38 A.M. from the causes and on the date stated above.											
22a. SIGNATURE M.E. Byrkit						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-23-67	
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit						22d. ADDRESS Williamsport Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 25-67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown Maryland		
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.						25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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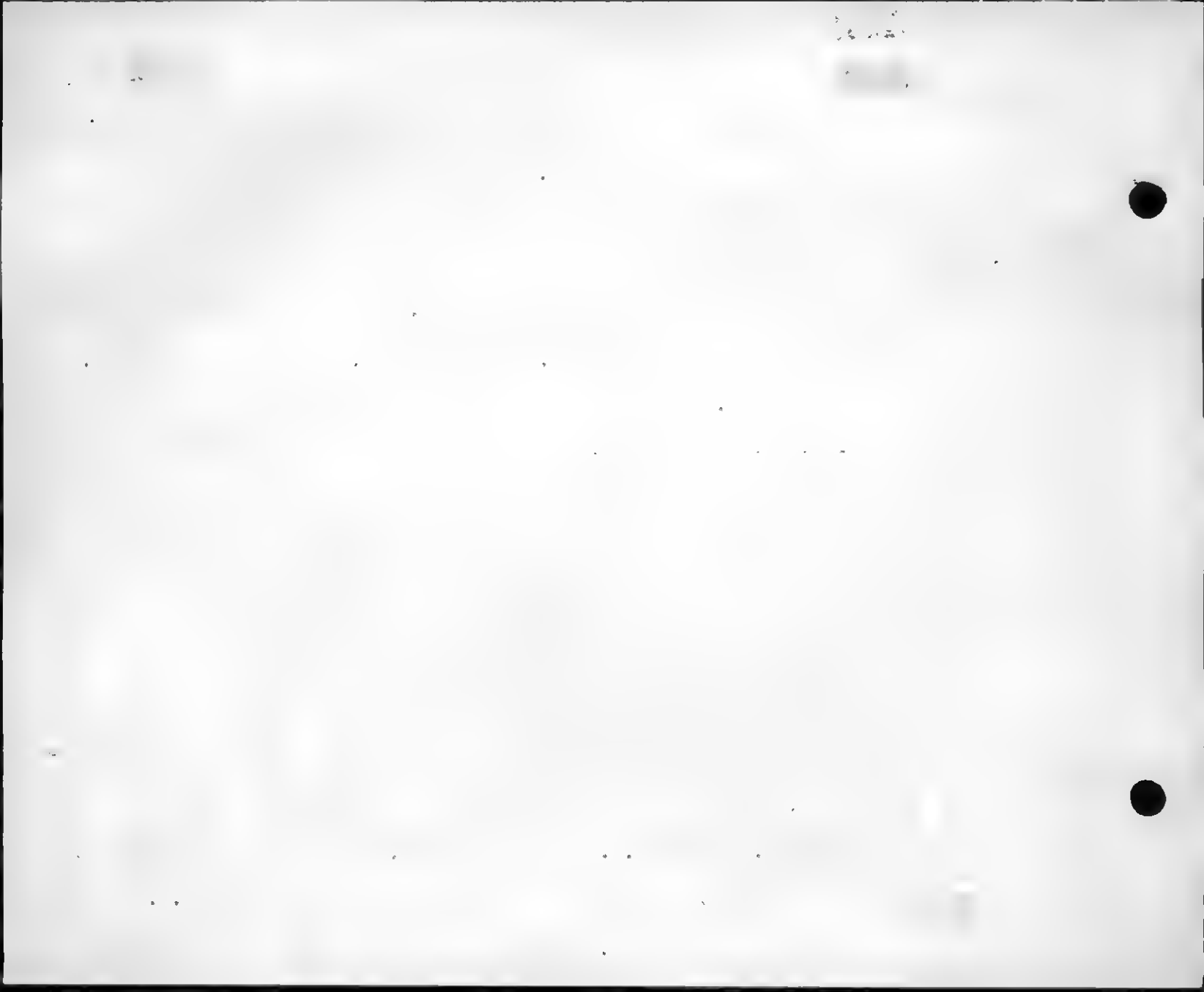
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04292

04294

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN TB <b>10 YRS.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>1016 POTOMAC AVENUE</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>MARY LEDBETTER HEGELER</b>		4. DATE OF DEATH Month Day Year <b>MARCH 15 19 67</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 22, 1913</b>	9. AGE (in years last birthday) <b>53 yrs</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MINING CORP.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CALHOUN CO., ALABAMA</b>	
13. FATHER'S NAME <b>EMMETT W. LEDBETTER</b>			14. MOTHER'S MAIDEN NAME <b>JESSIE JONES</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>111-22-7311</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MR. H. HARTLEY HEGELER 1016 POTOMAC AVE.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arterio sclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b> <b>18 hrs.</b> <b>5 mo.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1924</b> , 1957, to <b>1957-12</b> , 1967 that (I) (we) last saw the deceased alive on <b>March 15</b> 1967, and that death occurred at <b>4:15 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Lloyd A. Hoffman</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MFD. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LLOYD A. HOFFMAN M.D.</b>		22d. ADDRESS <b>214 N. POTOMAC ST. HAGERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE THEREOF <b>3/17/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON D.C.</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04293

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04298

1 PLACE OF DEATH a COUNTY <b>Washington</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a STATE <b>Maryland</b>		b COUNTY <b>Washington</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c LENGTH OF STAY IN b <b>Life</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d STREET ADDRESS <b>115 John St.</b>		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Norman Nelson Heller</b>		First Middle Last		4 DATE OF DEATH <b>March 25, 1967</b>		Month Day Year	
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Dec. 17, 1917</b>	
9 AGE (In years last birthday) yrs <b>49</b>		10a. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>		11 BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Nelson Heller</b>				14 MOTHER'S MAIDEN NAME <b>Ruth Sullivan</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>Yes W. W. Two</b>		16 SOCIAL SECURITY NO <b>212-14-7245</b>		17 INFORMANT <b>Mrs. E. Rebecca Heller, 115 John St.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced cirrhosis of the liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3/27/67 22. DATE SIGNED <b>580 Northern Ave. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-28-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Benevola Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Benevola, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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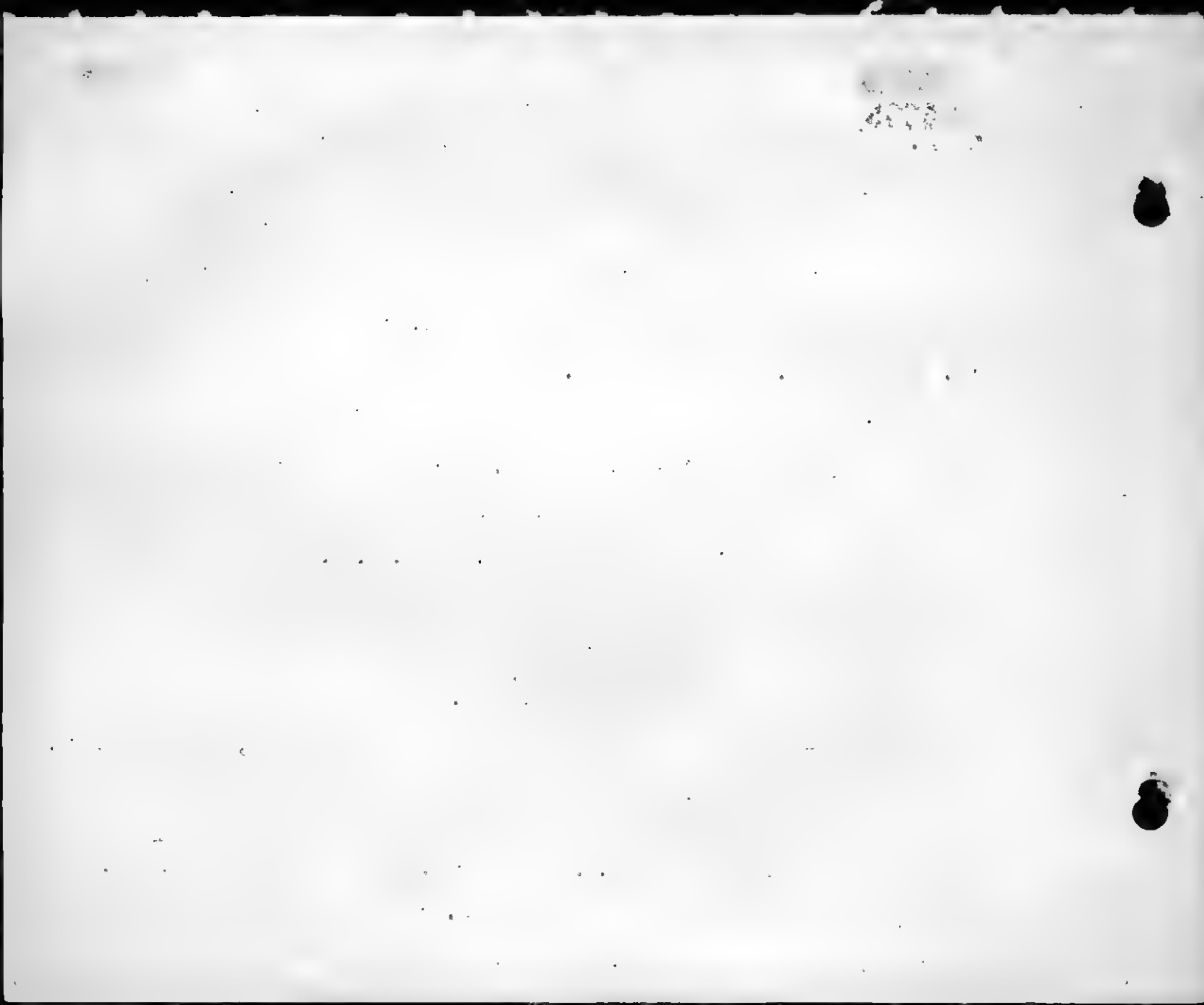
FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**04294 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04296**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>LIFE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>2014 GAY STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>STUART</b> Last <b>HESS</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>14</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT 10, 1901</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. TERMINAL MGR.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MAURICE HESS</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET SCHLEIGH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-10-4681</b>		17. INFORMANT <b>MRS. BERTIE HESS</b> Address <b>2014 GAY STREET</b> <b>MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Bilateral</b> <b>Several</b> days DUE TO (b) <b>Fracture Of Right 5th. &amp; 6th. Ribs.</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>A Possible Terminal Thrombotic Occlusion Of Anterior Descending</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Coronary Artery.</b> <b>Evidently fell in home.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Possible a.m. 3-11- 1967</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
20f. (City or town) <b>Hagerstown, Washington, Md.</b> (County) _____ (State) _____				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.O. _____				22. DATE SIGNED <b>3-17-67</b>			
EXAMINER'S NAME (Type) <b>EDWARD W. DITTO, JR. M.D. 215 W. WASH ST</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>HAGERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>				ADDRESS <b>HAGERSTOWN, MARYLAND</b>			
25a. REC'D BY REGISTRAR <b>MAR 21 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Rouzer</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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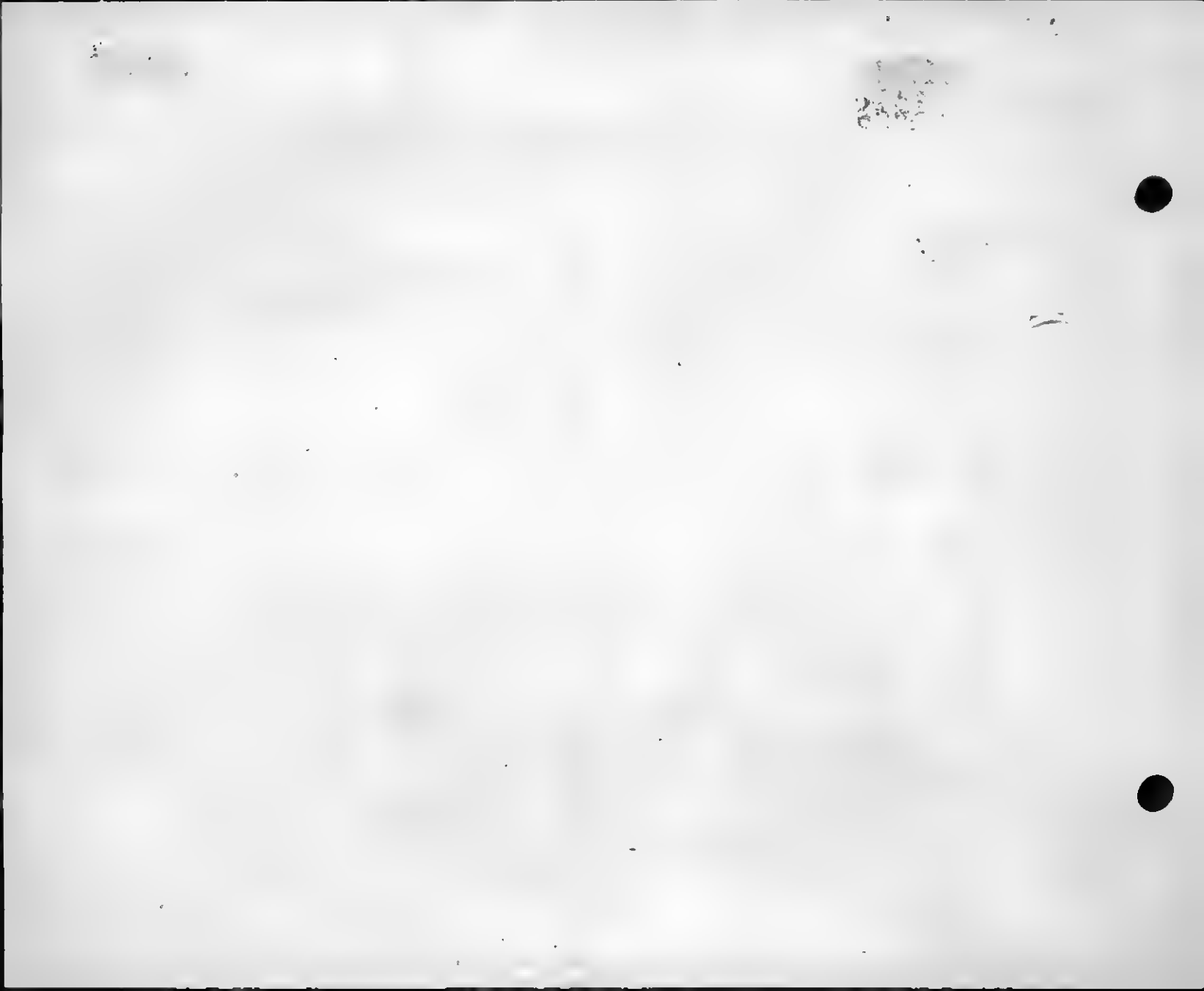
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04295

CERTIFICATE OF DEATH

04297

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Avalon Manor</b>		d. STREET ADDRESS <b>1011 Oak Hill Ave</b>	
3. NAME OF DECEASED (Type or print) <b>George Harlan Hornbaker</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 21, 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Division Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. M. Rwy. Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Mercersburg, Franklin Co U.S.A</b>
13. FATHER'S NAME <b>John Hornbaker</b>		14. MOTHER'S MAIDEN NAME <b>Jane E. Shatzer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO <b>A482822</b>	17. INFORMANT <b>Dr. John H. Hornbaker</b> Address <b>1117 Oak Hill</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Metastatic Sarcoma - to stomach</b> DUE TO (b) <b>Retroperitoneal Lympho Sarcoma -</b> DUE TO (c) <b>1 yr.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 11, 1967</b> , to <b>Mar 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Mar 27, 1967</b> , and that death occurred at <b>4 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Lloyd A. Hoffman</b>		22b. DATE SIGNED <b>3/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>		22d. ADDRESS <b>214 N. Pot. St. - Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>3/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>MAR 30 1967</b>	
<b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

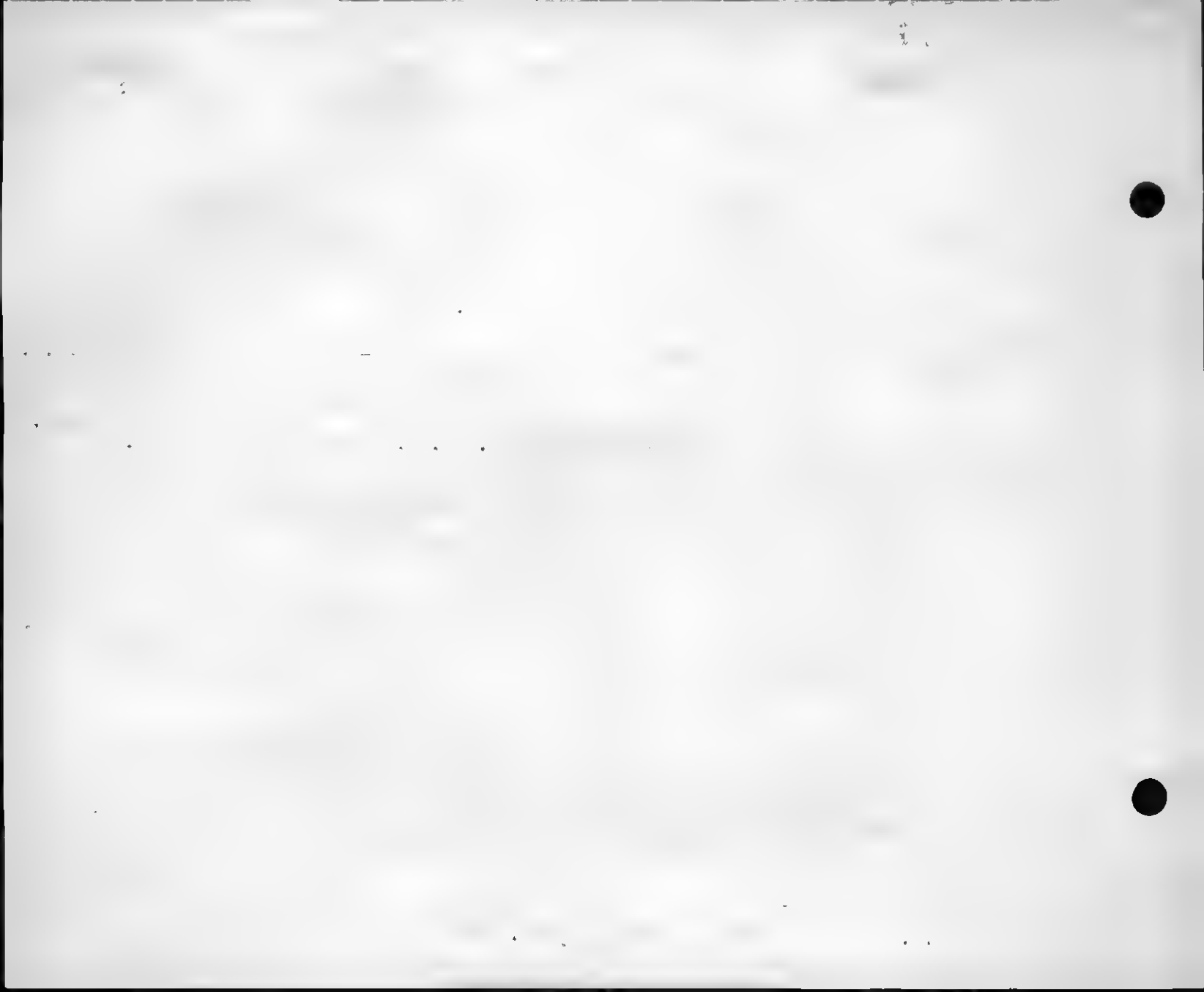
04296

04298

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
c. LENGTH OF STAY IN 1b <b>5 Mon.</b>		d. STREET ADDRESS <b>504 Valley Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mildred Claire Houchin</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12-1908</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Public Schools</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Fulton- Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lewis Houchin</b>		14. MOTHER'S MAIDEN NAME <b>Lennie Blanche Sims</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-4970</b>	
17. INFORMANT <b>Mrs. Wm. B. Gross-304 Central Ave.</b>		Address <b>Brunswick, Md.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>170X Generalized Carcinomatosis</b> IMMEDIATE CAUSE (a) <b>Carcinoma left breast</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1966</b> , to <b>March 24, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 24, 1967</b> , and that death occurred at <b>A. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Moran M.D.</b> M.D.		22b. DATE SIGNED <b>March 24-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. MORAN M.D.</b>		22d. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-28-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Fulton- Missouri 65251</b>
24. FUNERAL DIRECTOR <b>M.R. Etchison &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REC'D BY REGISTRAR <b>MAR 27 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

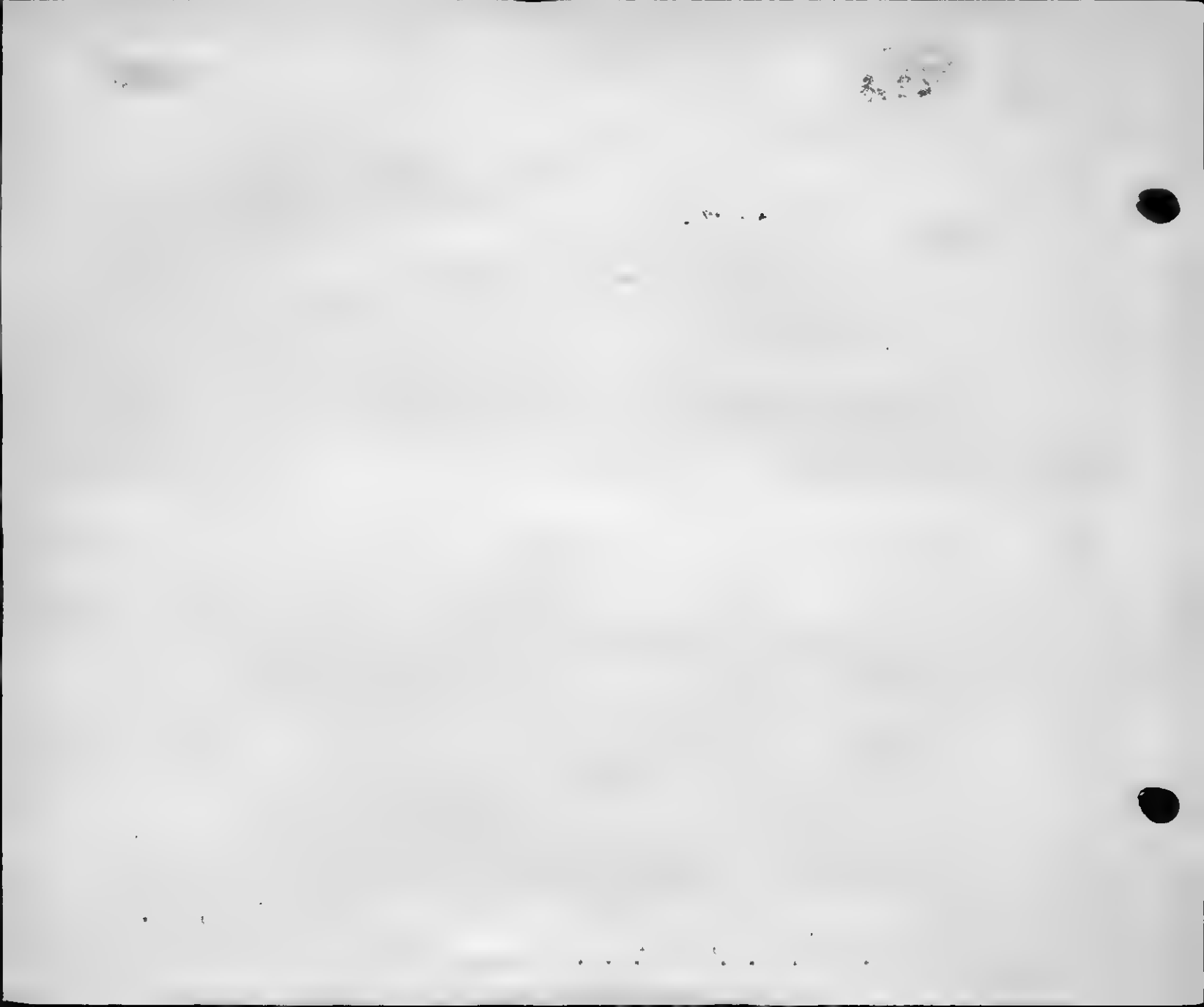
## CERTIFICATE OF DEATH

04297

04299

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bonobow</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hahoney-Leedy Memorial Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3601 Connecticut Ave., N.W.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Araminta</u>		<b>4. DATE OF DEATH</b> Last <u>Howell</u> Month <u>March</u> Day <u>28</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>DATE OF BIRTH</b> <u>June 28, 1877</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Berryville, Virginia</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Howell</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Bercheval, Emma</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> Address <u>—</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intermittent Heart Disease</u> DUE TO <u>Acute pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 1/2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Med 12</u>			
<b>20f. (City or town)</b> <u>Med 12</u>		<b>20g. (County)</b> <u>1</u>		<b>20h. (State)</b> <u>March 28, 1967</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>March 19, 1967</u> <b>to</b> <u>March 28, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10:15 am 3-28-67</u> <b>and that death occurred at</b> <u>10:30 am</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>G.W. Lavan</u>		<b>22b. DATE SIGNED</b> <u>March 28, 1967</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>G.W. Lavan</u>			
<b>22d. ADDRESS</b> <u>Bonobow Md</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE THEREOF</b> <u>3-31-1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Hill Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Berryville, Va.</u>		<b>23e. (State)</b> <u>—</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph Gawler's Sons, Inc.</u>		<b>24a. ADDRESS</b> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 31 1967</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>25c. (State)</b> <u>—</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after death.



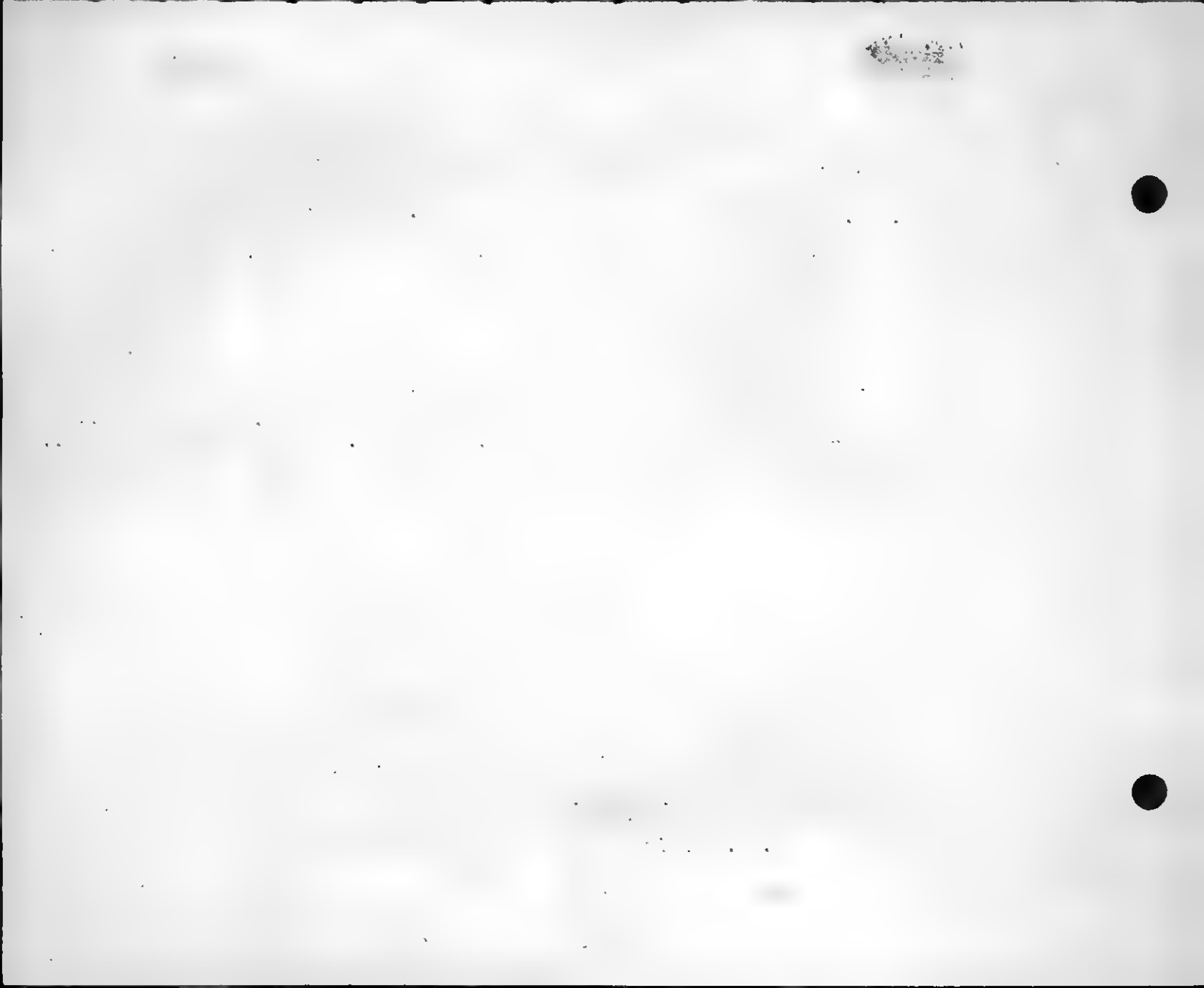
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**04298** **CERTIFICATE OF DEATH** **04300**

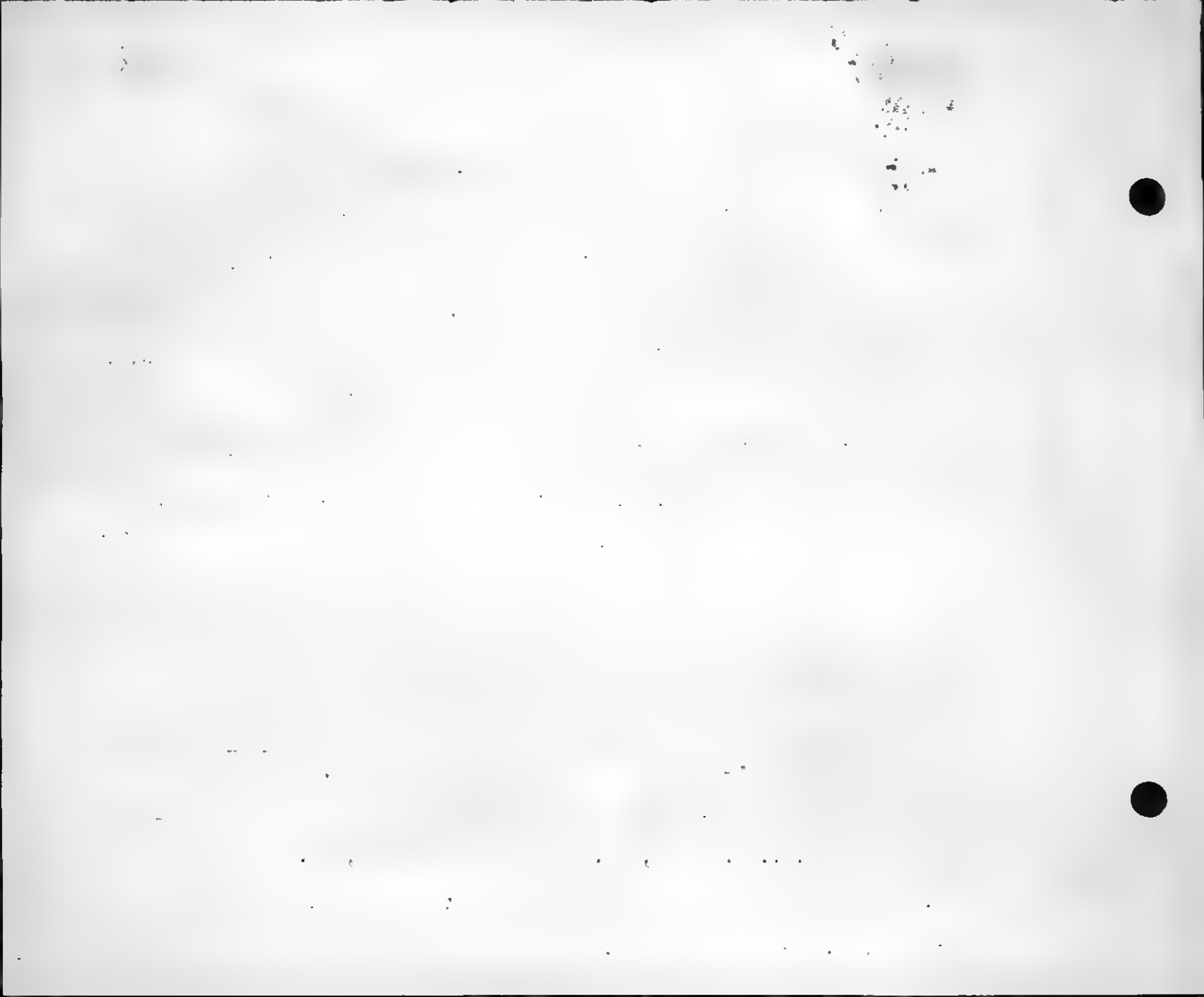
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>				c. LENGTH OF STAY IN 1b <b>37 yrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>24 E. Salisbury Street</b>				d. STREET ADDRESS <b>24 E. Salisbury St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>Kumler</b> Last <b>Huddle</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31 1898</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>David C Kumler</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle Fout</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218 30 9721B</b>		17. INFORMANT <b>24 E. Salisbury St.. Rev. William C. Huddle Williamsport Md..</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 min?</b> <b>5 yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) <del>was hospitalized</del> attended the deceased from <b>Nov 10</b> , 19 <b>58</b> , to <b>Mar 30</b> , 1967, that (ii) <del>was</del> last saw the deceased alive on <b>Feb 27</b> , 1967, and that death occurred at <b>12:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED <b>Mar 31 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit</b>				22d. ADDRESS <b>Williamsport Maryland 21795</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 1-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Williamsport Maryland</b>	
24. FUNERAL DIRECTOR <b>Mr. Albert L. Leaf Williamsport Md.</b>				25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04299 CERTIFICATE OF DEATH 04301

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 month</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Friendship Manor Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1931 Lincolnshire Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>William</b> Last <b>Huff</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24 1903</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>	9. AGE (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thomas Huff</b>		14. MOTHER'S MAIDEN NAME <b>Annie Cullison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b>214-09-9758</b>	
17. INFORMANT <b>Mrs. Blanche D Huff</b>		Address <b>1931 Lincolnshire Road Hagerstown Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Vascular Disease, Severe</b> 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemiplegia</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>3 years</b>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> , 19 <b>66</b> , to <b>3-13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2-18</b> , 19 <b>67</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. E. W. Ditto, Jr.</b>		22b. DATE SIGNED <b>3-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>March 15-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Williamsport Maryland</b>
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>		25a. REC'D BY REGISTRAR <b>16 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

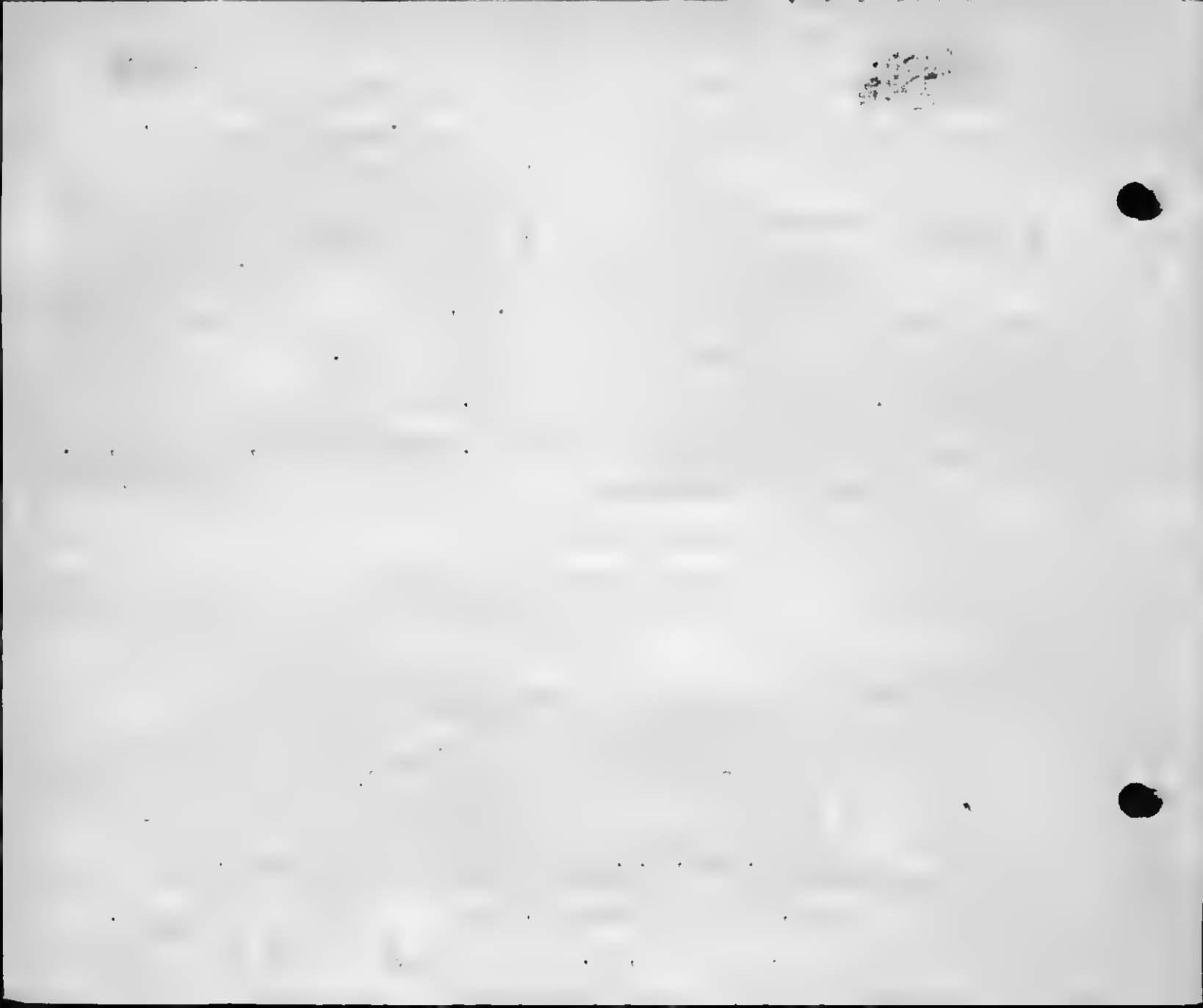
04300

## CERTIFICATE OF DEATH

04302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Wash.</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Smithsburg rural</u> d. STREET ADDRESS <u>RFD #2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Simon Verdene Huntsberry</u>				<b>4. DATE OF DEATH</b> <u>Mar. 1 1967</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 23, 1909</u>	
<b>9. AGE</b> (In years last birthday) <u>57</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Truck Farmer</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pondsville, Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Charles C. Huntsberry</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mrs. Onie Bear</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>214-09-9564</u>			
<b>17. INFORMANT</b> <u>Richard C. Huntsberry</u>				<b>Address</b> <u>RD#2, Smithsburg, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Phlebothrombosis</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 days</u>  <u>1 month</u>  <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9-27 1954</u> , <b>to</b> <u>3-1 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2-28-1967</u> , <b>and that death occurred at</b> <u>930</u> A.M., <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Charles F. Hess</u>				<b>22b. DATE SIGNED</b> <u>3-2-67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Charles F. Hess, M.D.</u>	
<b>22d. ADDRESS</b> <u>Smithsburg, Maryland 21783</u>				<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Mar. 4, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Smithsburg Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Smithsburg Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Minnich Funeral Home, Smithsburg, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

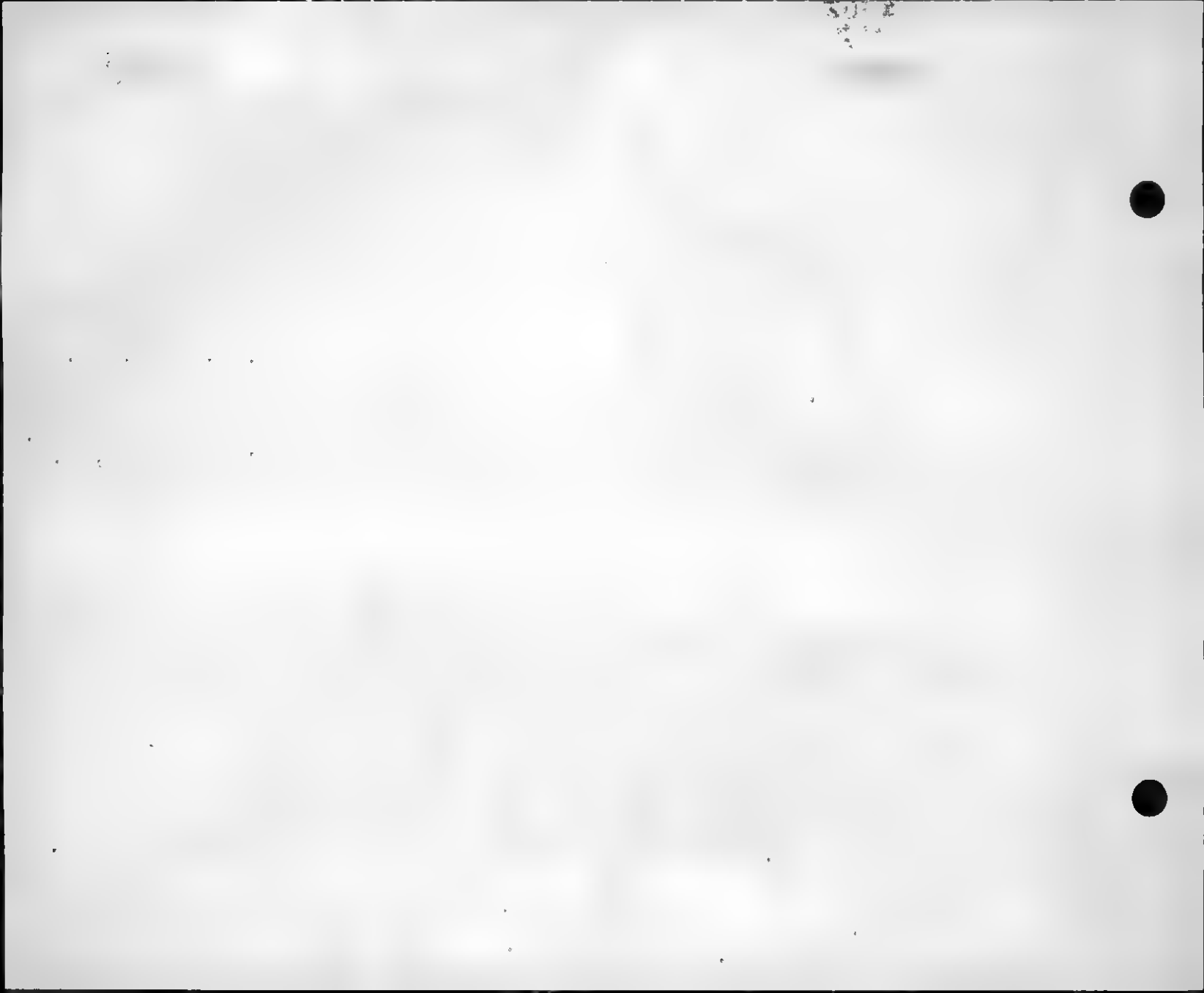
04301

CERTIFICATE OF DEATH

04303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>2 Weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>815 Antietam Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Effa</b> Middle <b>Dora</b> Last <b>Hykes</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1881</b>
9. AGE (in years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mason-Dixon Wash. Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Shubert</b>		14. MOTHER'S MAIDEN NAME <b>Alice Boward</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b> <b>None</b>		16. SOCIAL SECURITY NO. <b>214-48-3791</b>	
17. INFORMANT <b>Charles S. Hykes Jr.</b>		Address <b>815 Antietam Dr. Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-27, 1967</b> , to <b>3-1, 1967</b> , that (I) (we) lost saw the deceased alive on <b>2-27, 1967</b> , and that death occurred at <b>12:40 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A.M. Mandell M.D.</b>		22b. DATE SIGNED <b>3-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.M. Mandell M.D.</b>		22d. ADDRESS <b>119 East Antietam Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/3/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Broadforing, Wash. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Goffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 3 1967</b>	
Address <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

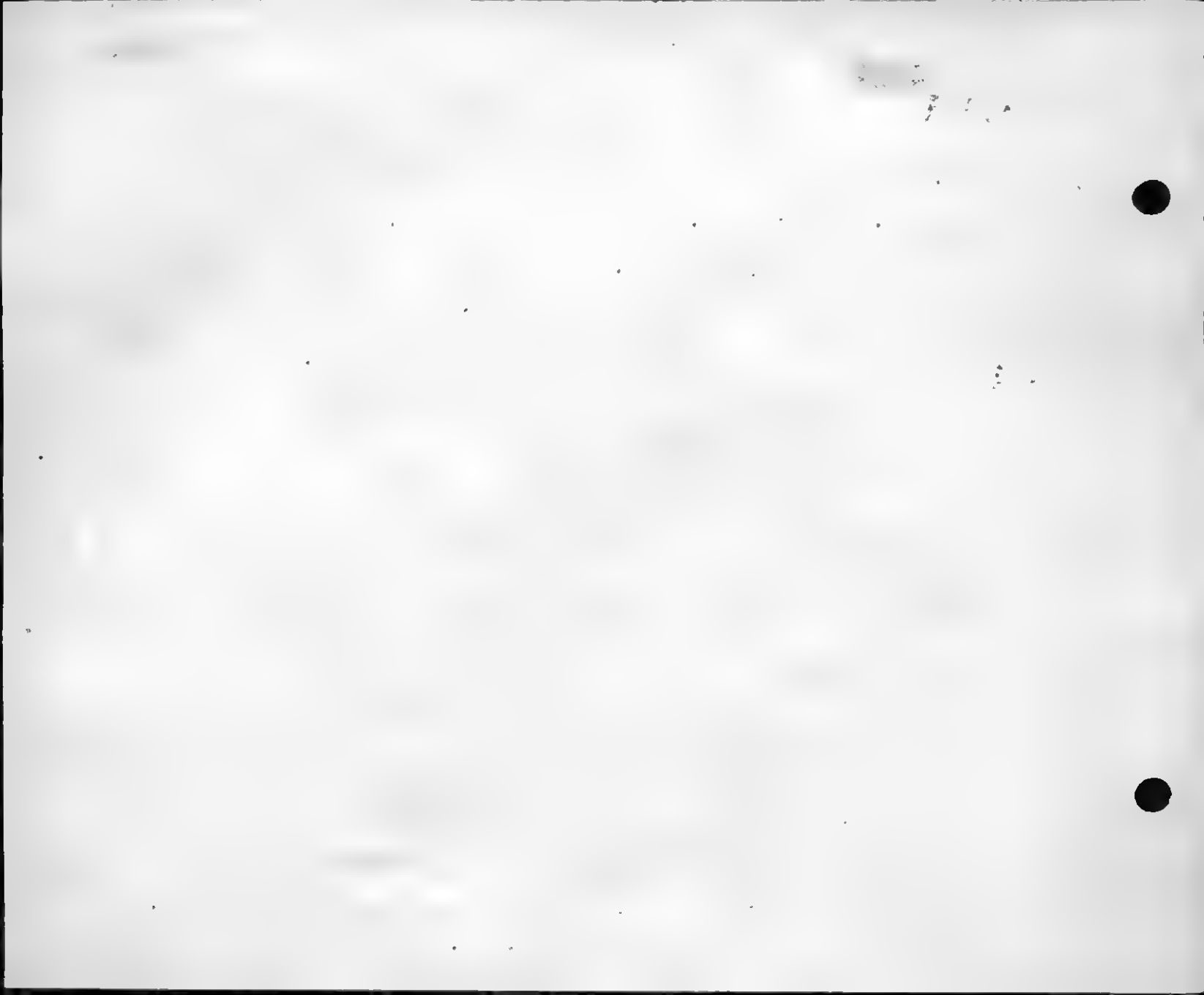
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04302

CERTIFICATE OF DEATH

04304

1 PLACE OF DEATH a COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Washington</b> b COUNTY <b>Maryland</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>316 N. Mulberry St.</b>		d. STREET ADDRESS <b>316 N. Mulberry St.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Grant S. Imboden</b>		4. DATE OF DEATH Month Day Year <b>March 17, 1967</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 26, 1903</b>
9 AGE (In years last birthday) yrs. <b>63</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>painting</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Annville, Pa.</b>	
12 CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Isaac Imboden</b>	
14 MOTHER'S MAIDEN NAME <b>Sarah Shenk</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>143-03-1091A</b>		17. INFORMANT Address <b>Kreamer Funeral Home Annville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Colorectal carcinoma of rectum &amp; sigmoid</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastasis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 year.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> , 19 <b>67</b> , to <b>3/17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/2</b> , 19 <b>67</b> , and that death occurred at <b>10:30 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Dr. George Jennings</b>		22b. DATE SIGNED <b>3/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. George Jennings</b>		22d. ADDRESS <b>Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Annville Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Annville, Pa.</b>
24 FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04303

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04305

1. PLACE OF DEATH  
a. COUNTY Washington MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb  
Hagerstown Maryland 60 yrs  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  
159 W. Washington Street  
3. NAME OF DECEASED First Last Middle  
Ashby (no) Jackson  
5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH April 22 1881  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?  
Laborer Private family Rappahannock, Va. USA.  
13. FATHER'S NAME Martin Jackson 14. MOTHER'S MAIDEN NAME Janie Grigsby  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT  
no 216-14-5167 Mrs. Kathryn G. Butler Harrisburg, Pa.  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 4201 DUE TO Coronary occlusion  
(b) General arteriosclerosis & atherosclerosis - 25 yrs  
(c) sclerotic heart disease  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month Day Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
Hour a.m. p.m. 19 at work ☐ Not while at work ☐  
21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE Edward W. Ditto III M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) DATE SIGNED 3-13-67  
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State)  
Burial 3-15-1967 Rose Hill Cemetery Hagerstown, Md.  
23. FUNERAL DIRECTOR ADDRESS  
John K. Watson Hagerstown Md.  
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  
MAR 15 1967 Charles Judge

1073

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04304

CERTIFICATE OF DEATH

04306

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md</b> c. LENGTH OF STAY IN 1b <b>60 yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State Hospital</b>		d. STREET ADDRESS <b>456 Park Place</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Moll Jones</b>		4. DATE OF DEATH Month <b>March</b> , Day <b>13</b> , Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1898</b>
9. AGE (In years lost birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> , Days <b>0</b> , Hours <b>0</b> , Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mill</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Rippon, W. Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>Thomas Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Laura Helms</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes World War 1</b>	
16. SOCIAL SECURITY NO <b>217-10-3256</b>		17. INFORMANT <b>Mrs. Hattie Jones</b> Address <b>456 Park Place.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>carcinomatosis</b> DUE TO (b) <b>bronchogenic carcinoma</b> DUE TO (c) <b>1621</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>7 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1-9</b> , 19 <b>67</b> to <b>3-13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>March 13</b> , 19 <b>67</b> , and that death occurred at <b>6:30 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramas</b>		22b. DATE SIGNED <b>March 14, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMAS, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-18-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md.</b>
24. FUNERAL DIRECTOR <b>John R. Watson Jr. Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 20 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

04305

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04307

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 16 <b>43 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>513 W. Howard St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>513 W. Howard St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>SHARPE</b> Last <b>KARPER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1885</b>
9. AGE (In years last birthday) yrs <b>81</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>dairy business</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Franklin Co., Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>W. Edward Karper</b>		14. MOTHER'S MAIDEN NAME <b>Della Laughlin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-44-6357</b>	
17. INFORMANT <b>Sharpe D. Karper, Perryville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO (b) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>arteriosclerotic (Coronary) Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>found dead in bed - 1 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>myocardial infarction Oct 1965</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-23, 1951</b> , to <b>3-13, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-23, 1967</b> , and that death occurred at <b>2:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John H. Hornbaker, M.D.</b>		22b. DATE SIGNED <b>3-13-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-15-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Norland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Chambersburg, Penna.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. RECORD BY REGISTRAR <b>MAR 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John H. Hornbaker</b>			

2076

1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04306**

**CERTIFICATE OF DEATH**

**04308**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Cleo</b> Last <b>Keefer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1880</b>
9. AGE (In years last birthday) yrs. <b>86</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <b>Williamsport, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Ward</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Keefer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Christine Hope, Mt. Rainier, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <b>nephrosclerosis</b> DUE TO (c) <b>arteriosclerosis, general</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>unknown</b> <b>"</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 4, 1966</b> , to <b>March 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 20, 1967</b> , and that death occurred at <b>7:03pm</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Victor L. Ramos</b>		22b. DATE SIGNED <b>March 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Victor L. Ramos, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>3-23-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Stone Bridge Breth Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Millstone, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

10.11.20



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04307

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04309

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hagerstown R # 4</b> c. LENGTH OF STAY IN IL <b>11 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Salem Church Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hagerstown R # 4</b> d. STREET ADDRESS <b>Salem Church Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SAMUEL CALVIN KING Jr</b> First Middle Last		4. DATE OF DEATH <b>March 28 1967</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23 1904</b>
9. AGE (In years last birthday) <b>62</b> yrs		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel C. King Sr</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Springer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-09-9945</b>	
17. INFORMANT <b>Mrs Mary A King</b>		Address <b>R#4 Hagerstown Md</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>976X</b> IMMEDIATE CAUSE (a) <b>Gunshot Wound Of Head (Self Inflicted)</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Self inflicted gunshot wound of head.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9 3-28- 19 67</b> Hour a.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown, Washington, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. W. Ditto, Jr.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>3-30-67</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/31/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1954



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04308**

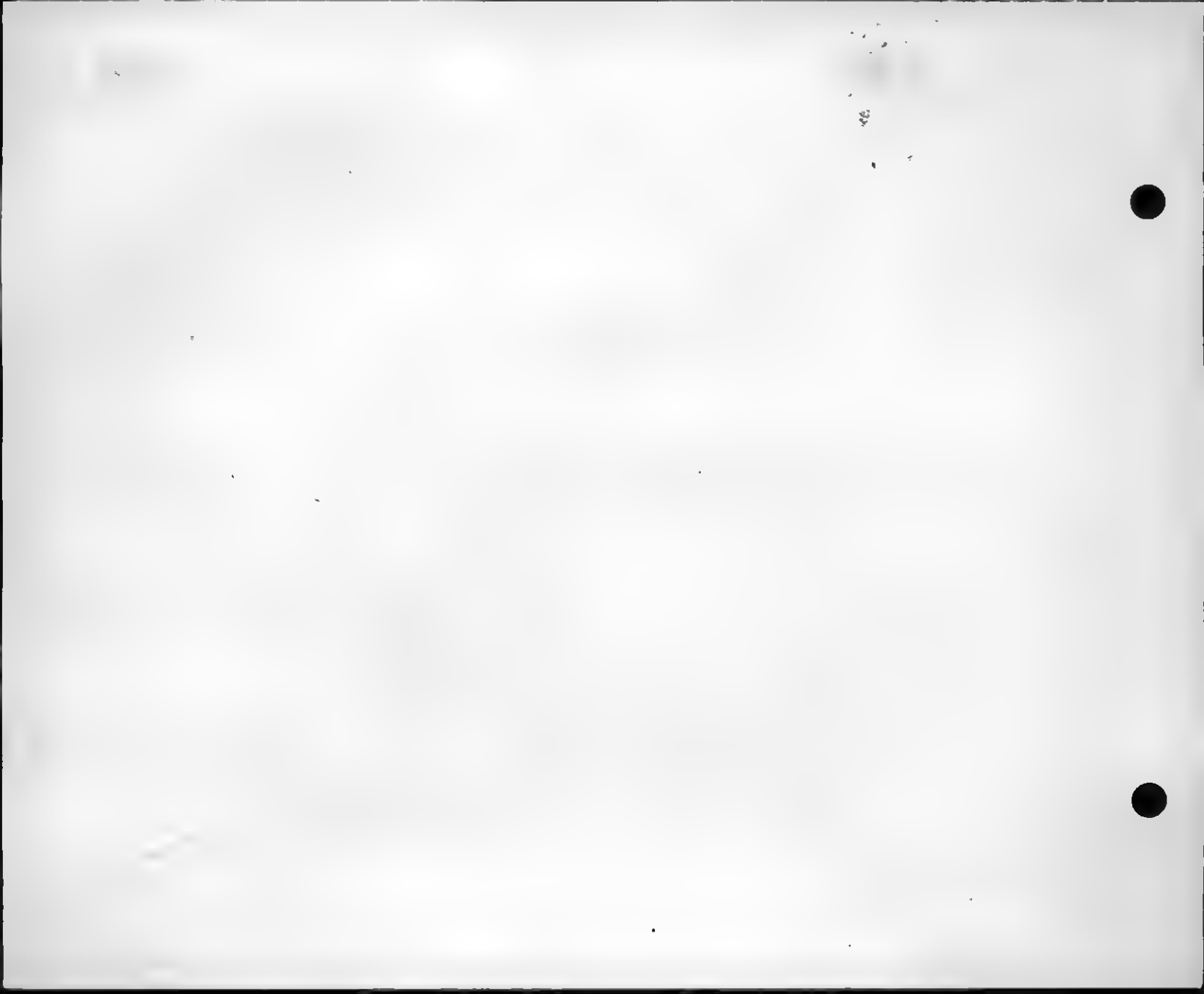
**CERTIFICATE OF DEATH**

**04310**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. <b>PLACE OF DEATH</b> a. COUNTY <b>Washington</b> MARYLAND			2. <b>USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN IB <b>2 Weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Memorial Home</b>			d. STREET ADDRESS <b>714 George St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. <b>NAME OF DECEASED</b> (Type or print) First <b>MARY</b> Middle <b>IRENE</b> Last <b>KLINE</b>			4. <b>DATE OF DEATH</b> Month <b>March</b> Day <b>30</b> Year <b>1967</b> 19		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1 1891</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Westminster Carroll Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jesse Fritz.</b>			14. MOTHER'S MAIDEN NAME <b>Valana McKane</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-16-3797</b>	17. INFORMANT <b>Frisby S. Kline</b> Address <b>714 George St Hagerstown Md.</b>		
18. <b>CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 11200 DUE TO (b) <b>8/2/67</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychoses</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/18</b> , 19 <b>65</b> to <b>3/30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3/30</b> , 19 <b>65</b> , and that death occurred at <b>5:00 PM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Donald E. Martin</b>			22b. DATE SIGNED <b>3/31/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Donald E. Martin, M.D.</b>			22d. ADDRESS <b>418 N. Potomac St., Hagerstown, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>		
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b> Hagerstown Md. ADDRESS <b>Funeral Home Inc</b>			25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**04309**

**04311**

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Part 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>WEST VIRGINIA</b> b COUNTY <b>WEST VIRGINIA</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c LENGTH OF STAY IN It <b>85-3</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>			d. STREET ADDRESS <b>HOSPITAL U.S. VETERANS ADMINISTRATION</b>		
3 NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>LEIDMAN</b> Last <b>LEIDMAN</b>			4 DATE OF DEATH <b>MARCH 16, 1967</b>		
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JUNE 29, 1923</b>	9 AGE (In years last birthday) <b>43</b> yrs	10 IF UNDER 1 YEAR Months Days IF UNDER 74 HRS. hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL MAINT.</b>	11 BIRTHPLACE (State or foreign country) <b>NEW YORK CITY</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>
13 FATHER'S NAME <b>ABRAHAM LEIDMAN</b>			14 MOTHER'S MAIDEN NAME <b>JENNIE RESNICK</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES W.W. II</b>		16 SOCIAL SECURITY NO <b>UNKNOWN</b>	17. INFORMANT Address <b>SCHWARTZ BROS., 114-03 QUEENS BLVD., FOREST HILLS, NY</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fractured Skull Fractured Femur 4+T</b> DUE TO (b) <b>(Crushed Chest) Multiple Fractures of Ribs</b> DUE TO (c) <b>Fractured</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Head on collision with oncoming car</b>			
20c. TIME OF INJURY Month, Day, Year <b>3:13 p.m. 3-16-67</b>		20d INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>State St</b>	20f (City or town) <b>Williamstown West Md</b>	(County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>J. E. W. D. T. T. O. P.</b> M.D.		22. DATE SIGNED <b>3/16/67</b>			
EXAMINER'S NAME (Type) <b>J. E. W. D. T. T. O. P.</b>		DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>3/19/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>MONTIFLORE</b>		23d LOCATION (City or Town) (County) (State) <b>SPRINGFIELD, LONG ISLAND, NY</b>	
24 FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC., 6010 REIST., RD.</b>		25a REC'D BY REGISTRAR <b>MAR 21 1967</b>		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

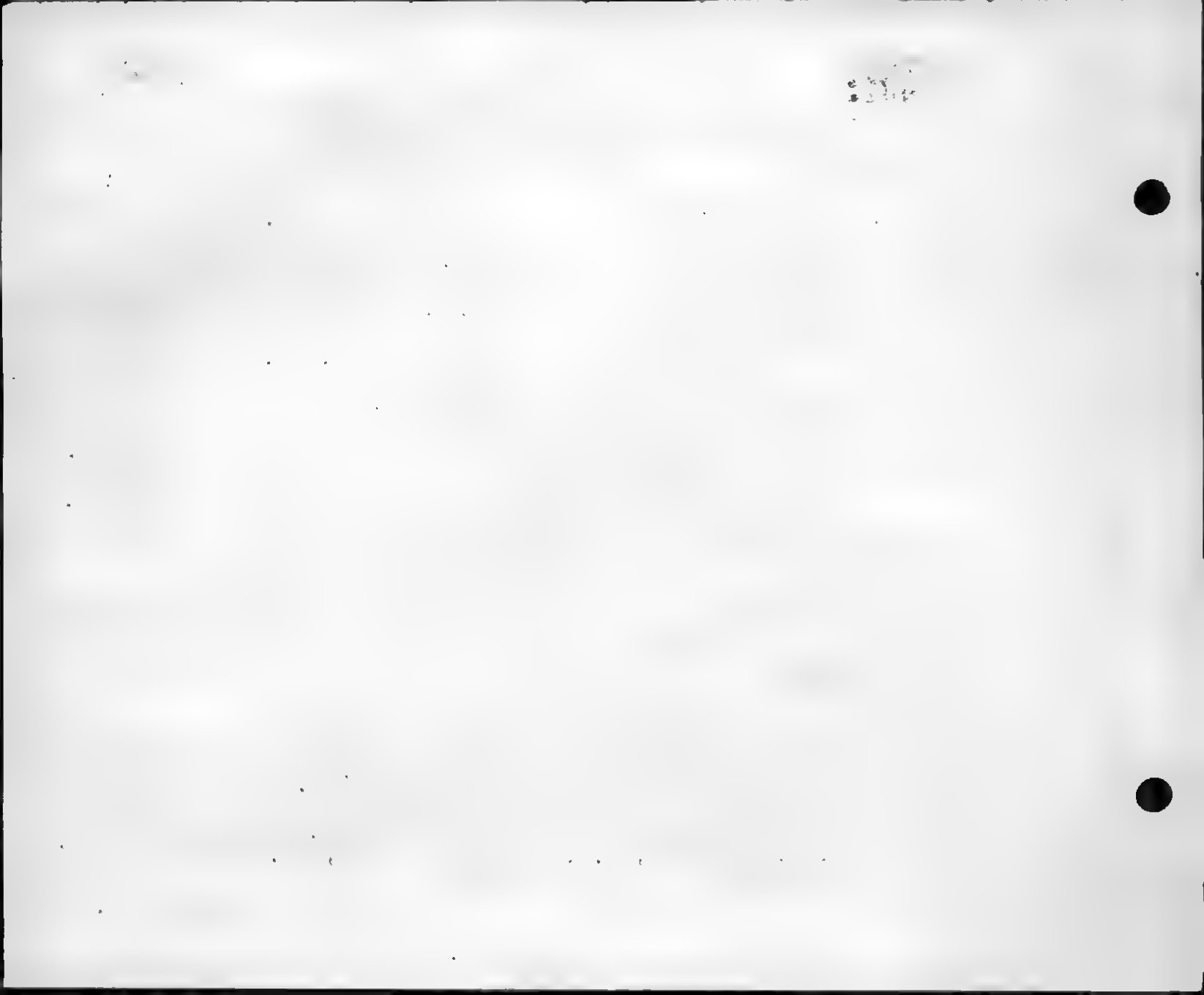
MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04310

CERTIFICATE OF DEATH

04312

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>402 Liberty St.</b>	
3 NAME OF DECEASED (Type or print) <b>Fred Lee Lushbaugh</b>		4 DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8-26-14</b>
9 AGE (In years last birthday) yrs. <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>beauty supply</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <b>Fred Lushbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Maude Boward</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-7998</b>	
17. INFORMANT <b>June Lushbaugh</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolism with infarction</b> DUE TO (b) <b>Chronic endocarditis with congestive failure</b> DUE TO (c) <b>Indefinite</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1966</b> to <b>March 8, 1967</b> that (I) (we) last saw the deceased alive on <b>March 8, 1967</b> , and that death occurred at <b>4:55 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>3/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>3-11-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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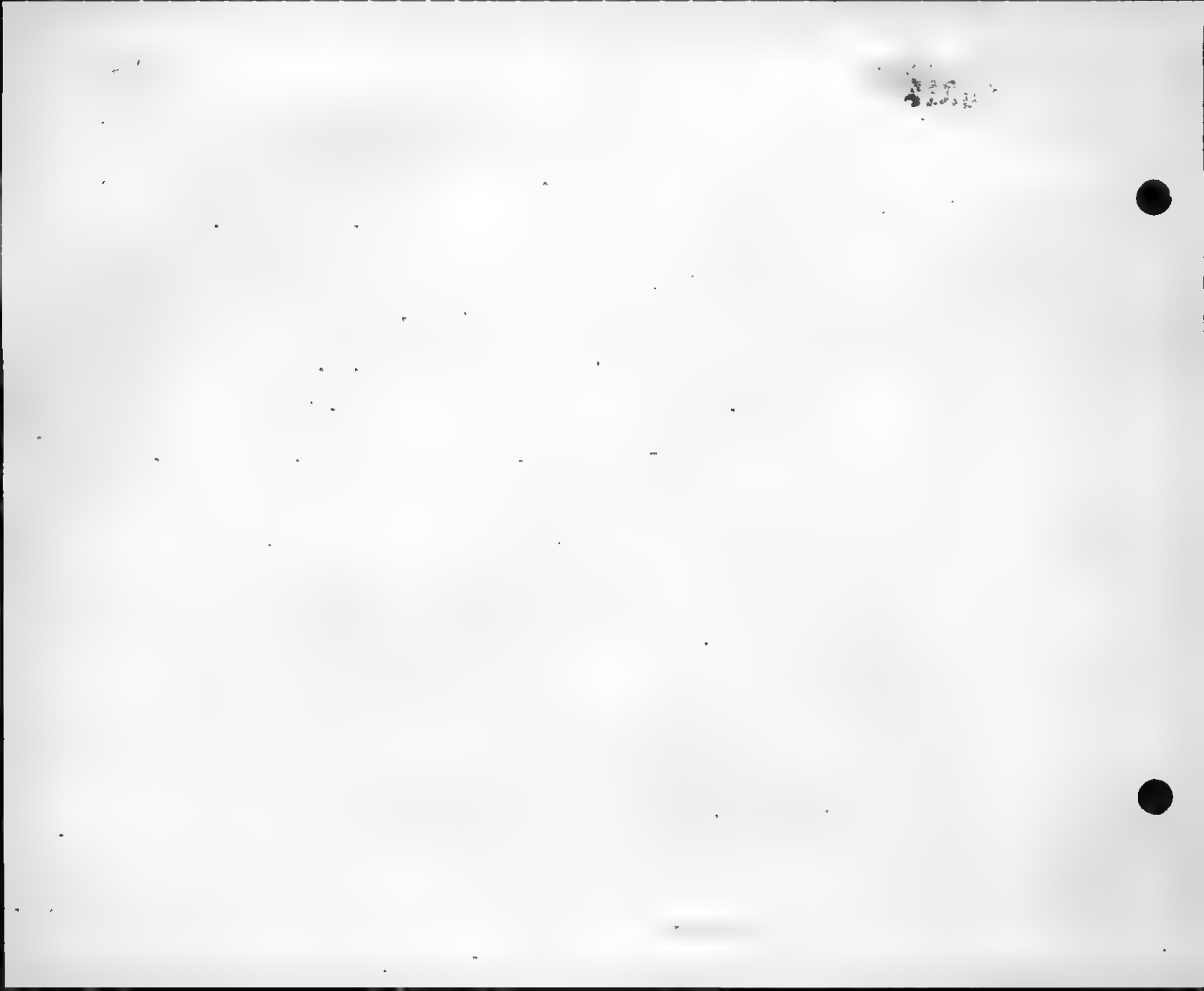
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04317

CERTIFICATE OF DEATH

04313

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>122 S. Mulberry St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Catherine</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 5, 1917</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert E. Ruby</u>		14. MOTHER'S MAIDEN NAME <u>Grace A. Goetz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-0303</u>	
17. INFORMANT <u>C. Edgar Martin</u>		Address <u>122 S. Mulberry St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>Adeno-Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Uterine</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1959</u> to <u>March 25, 1967</u> , that (II) (we) last saw the deceased alive on <u>March 24, 1967</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>3-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>WilliamSPORT Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. A. Henk</u> <u>Rest Haven Funeral Chapel</u>		25. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

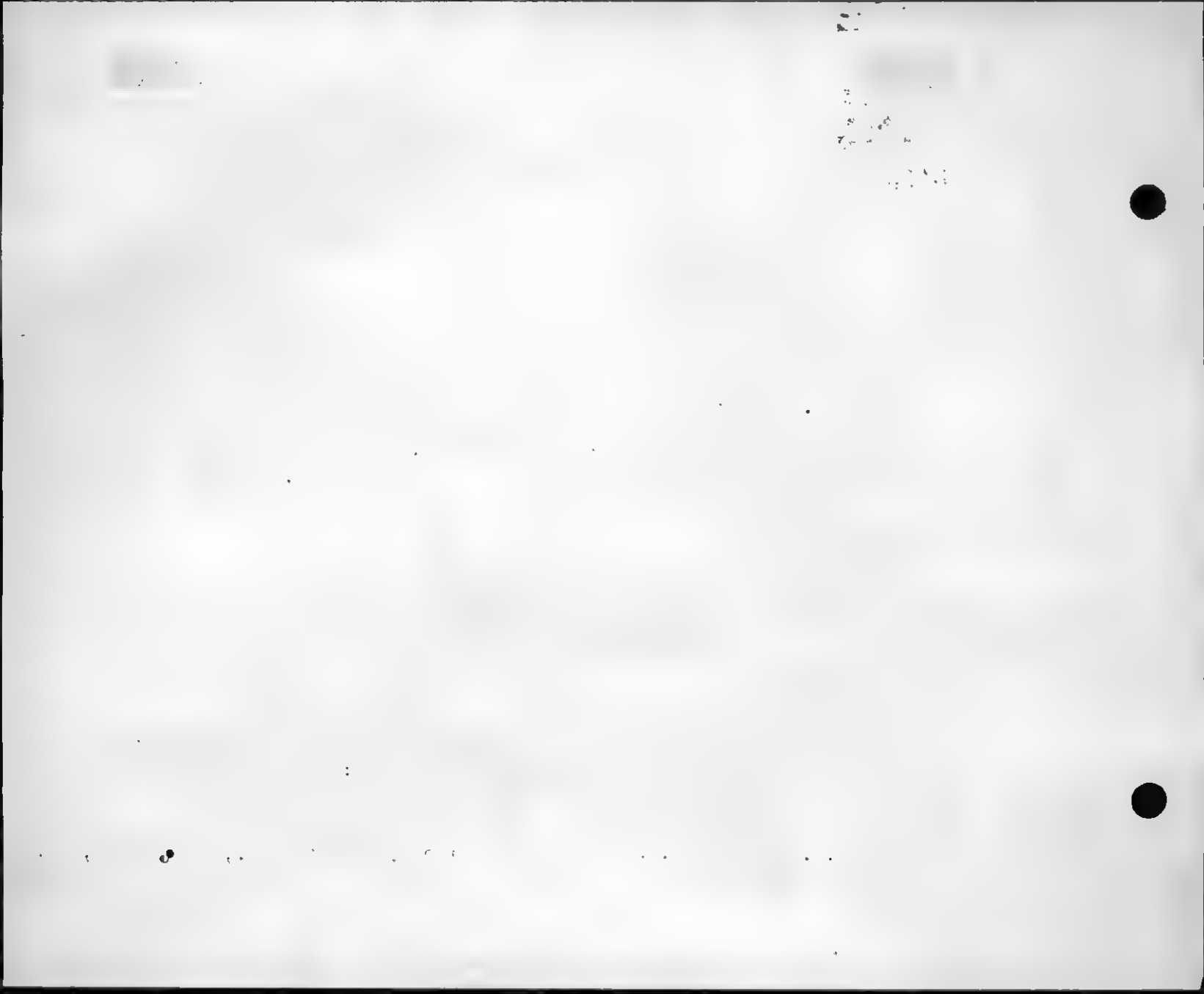
**04312**

**CERTIFICATE OF DEATH**

**04314**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if instit. on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>351 Brookline Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FREDERICK MERLE MAYHUE</b>				4. DATE OF DEATH Month Day Year <b>March 6 1967 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 21 1905</b>		9. AGE (In years last birthday) yrs <b>61</b>	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Corp</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Boonsboro Wash Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry W. Mayhue</b>				14. MOTHER'S MAIDEN NAME <b>Amanda E. Hoover</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>217-32-6181</b>		17. INFORMANT Address <b>James F. Mayhue Paradise Church Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 1'21 IMMEDIATE CAUSE (a) <b>Branchogenic Carcinoma</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____ DUE TO (c) _____				Hagerstown Md. R # 6		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1966</b> , to <b>March 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1967</b> , and that death occurred at <b>7:05 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>A.M. Mandell</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A.M. Mandell M.D.</b>				22d. ADDRESS <b>119 E. Antietam St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Hagerstown Md. ADDRESS</b> <b>Andrew K. Coffman Funeral Home Inc</b>				25a. REC'D BY REGISTRAR <b>MAR 10 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





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VR A15 (4)  
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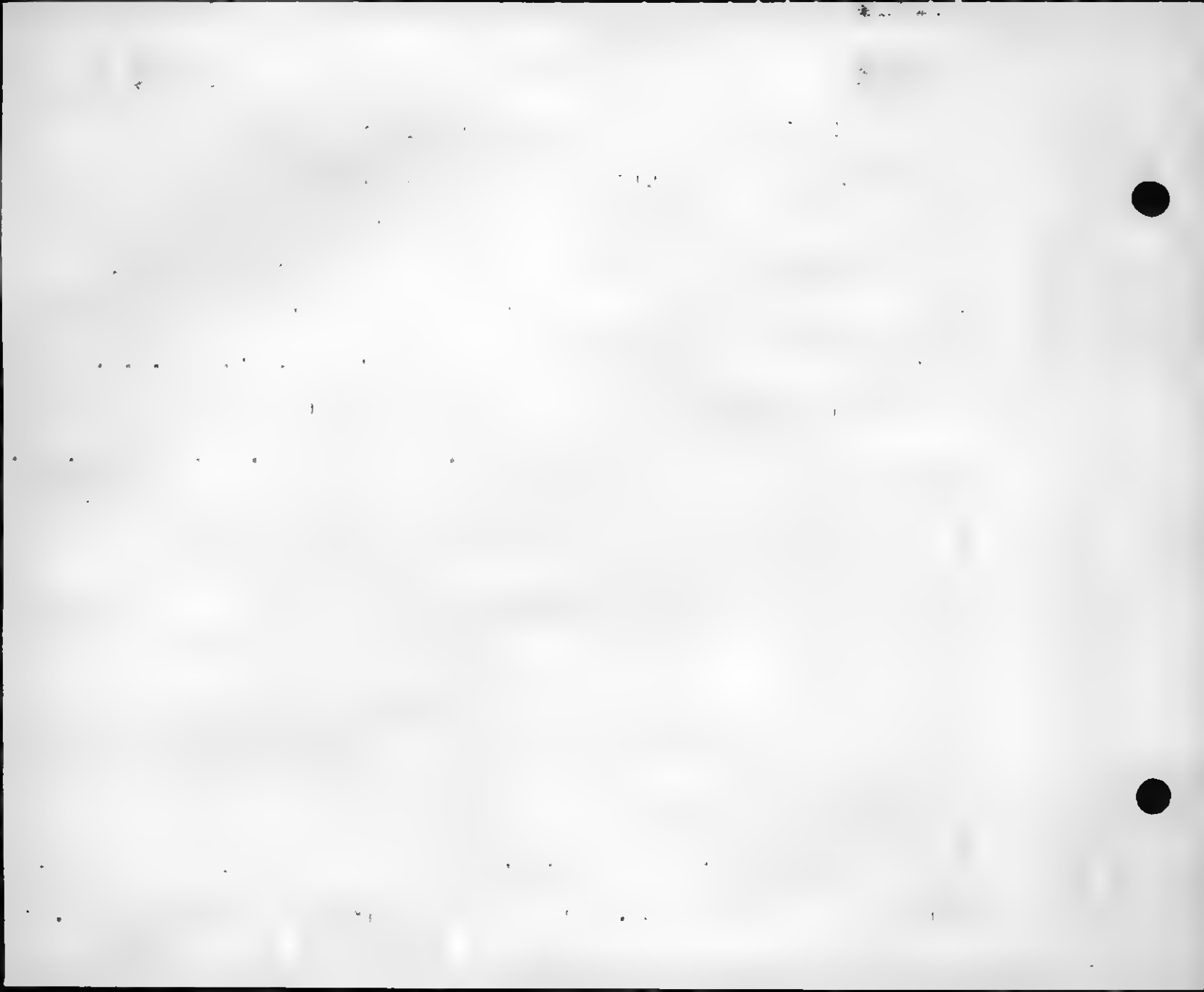
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04313

CERTIFICATE OF DEATH

04315

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RURAL HANCOCK</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b> d. STREET ADDRESS <b>RURAL HANCOCK</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT WALLACE MCCUSKER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/17/1900</b>
9. AGE (In years last birthday) <b>67</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b>	11. IF UNDER 24 HRS. Hours <b>17</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN WILLIAM MCCUSKER</b>	
14. MOTHER'S MAIDEN NAME <b>NANCY VIRGINIA BARNHART</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>NO</b>		17. INFORMANT <b>JOHN L. MCCUSKER RD. #1, HANCOCK, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-20</b> , 19 <b>67</b> , to <b>2-21</b> , 19 <b>67</b> ; that (I) (we) last saw the deceased alive on <b>2-21</b> , 19 <b>67</b> , and that death occurred at <b>2-21</b> , 19 <b>67</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles R. Wierer</b>		22b. DATE SIGNED <b>3-9-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles R. Wierer, M. D.</b>		22d. ADDRESS <b>238 E. Main St., Hancock, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/11/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET PRESBYTERIAN</b>		23d. LOCATION (City or Town) (County) (State) <b>RURAL HANCOCK WASH. MD.</b>	
24. FUNERAL DIRECTOR <b>Harold J. Lane</b>		25a. REC'D. BY REGISTRAR <b>DATE MAR 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

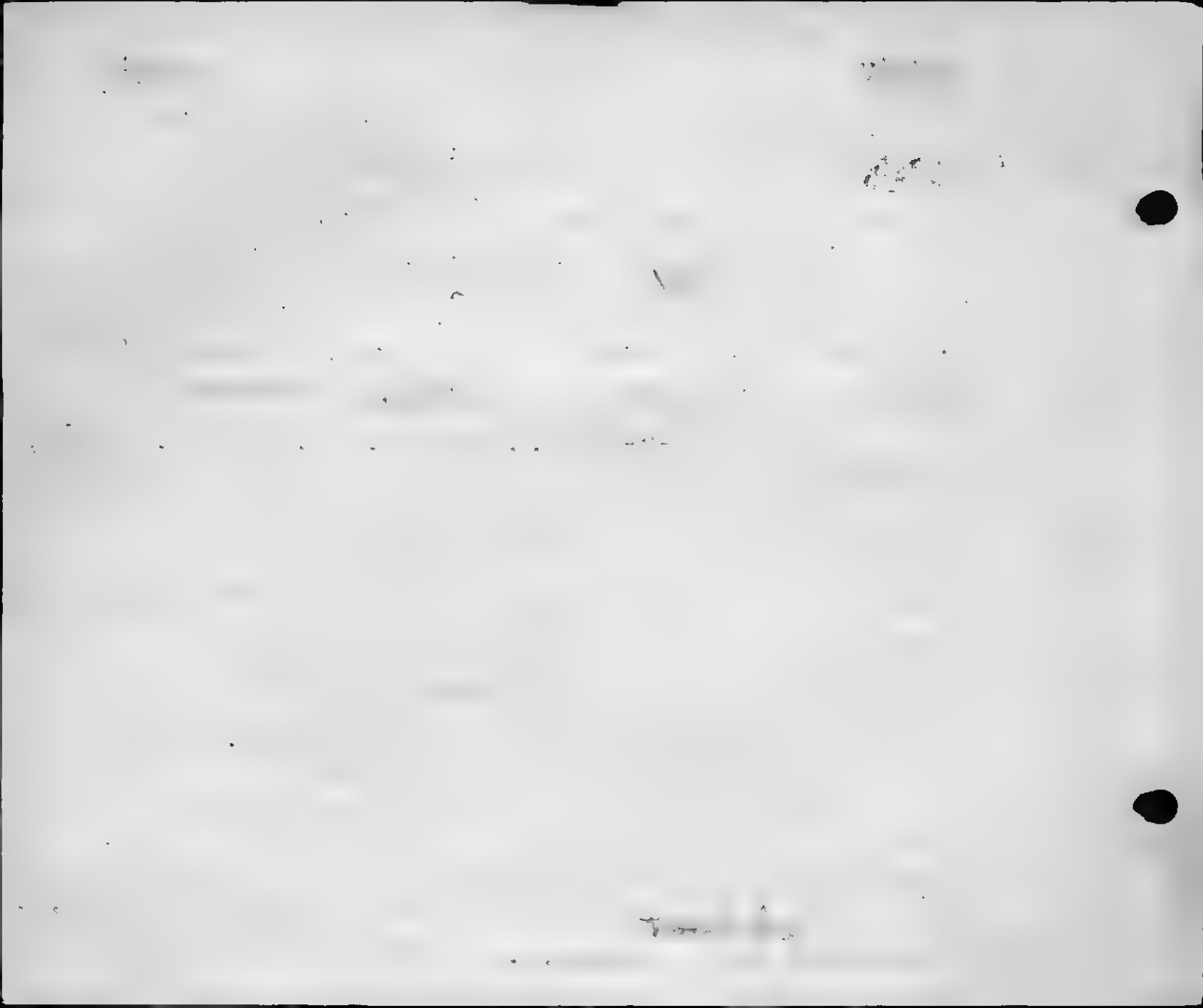
## CERTIFICATE OF DEATH

04314

04317

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Boonsboro Md.</u> c. LENGTH OF STAY IN 1b <u>3 years</u> NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pachony-Keedy Memorial Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>16 North Mulberry Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Orda Beachley McFadyen</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>15</u> Year <u>1967</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11/3/1876</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife &amp; Sew</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Furniture</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>E. Beachley</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Main</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-16-0538</u>	
<b>17. INFORMANT</b> <u>D.R. Beachley Sr.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis cardio vascular</u> Conditions, if any, which gave rise to immediate cause (b) <u>Disease</u> (c), stating the underlying cause last. <u>Disease</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>e.m.</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 4, 1967</u> <b>to</b> <u>March 15, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>March 15, 1967</u> <b>and that death occurred at</b> <u>12 noon</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>G. W. LeVan</u>		<b>22b. DATE SIGNED</b> <u>March 15, 1967</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>G. W. LeVan</u>		<b>22d. ADDRESS</b> <u>Boonsboro, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>3/18/67</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Church Of Brethern Cemetery</u>	<b>23d. LOCATION (City, town or county) (State)</b> <u>Beaver Creek, Washington, Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. G. Nant</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 16 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>25c. ADDRESS</b> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

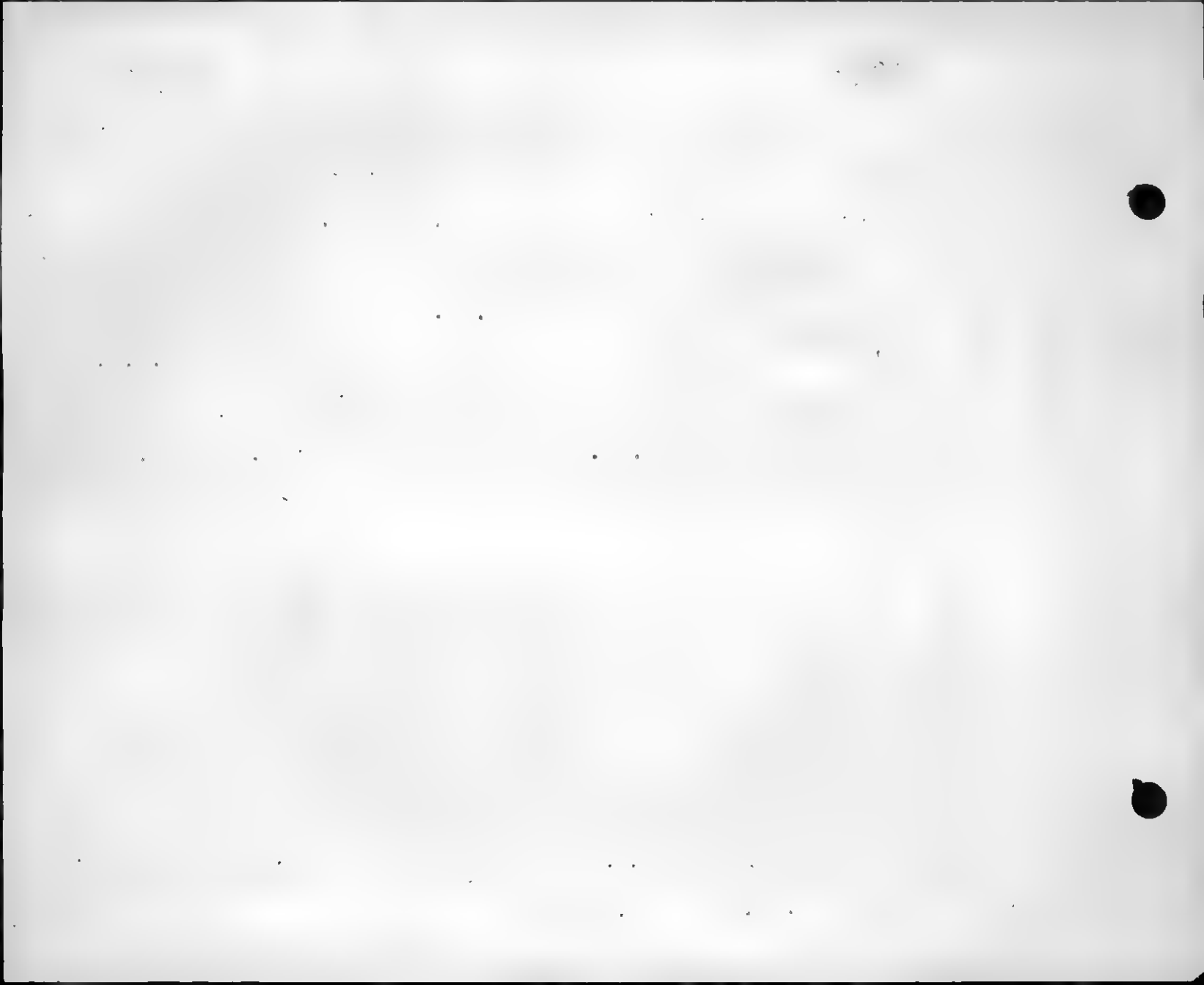
04315

CERTIFICATE OF DEATH

04316

1 PLACE OF DEATH a COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c LENGTH OF STAY IN 1b 3 WKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e STREET ADDRESS W. MAIN ST.	
3 NAME OF DECEASED (Type or print) MARGARETTA RUTH MCKINLEY		4 DATE OF DEATH 3 18 19 67	
5 SEX F	6. COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5.26.1908
9 AGE (In years last birthday) yrs 58		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) HANCOCK MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W WHORTON		14. MOTHER'S MAIDEN NAME BEULAH BARNHART	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 220.26.0632	
17. INFORMANT A HART MCKINLEY W. MAIN ST. HANCOCK		Address MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Breast with Metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1962 to 3-18, 1967, that (I) (we) last saw the deceased alive on 3-18 1967, and that death occurred at 4:35 p.m. from causes and on the date stated above.			
22a SIGNATURE <u>Dalton J. Welty</u>		22b DATE SIGNED 3/20/67	
22c PHYSICIAN'S NAME (Type) Dalton J. Welty, M.D.		22d ADDRESS 998 Potomac Ave., Hagerstown, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 3.21.67	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET	23d LOCATION (City or Town) (County) (State) RURAL HANCOCK WASHINGTON
24. FUNERAL DIRECTOR Houder & Glave		25a REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



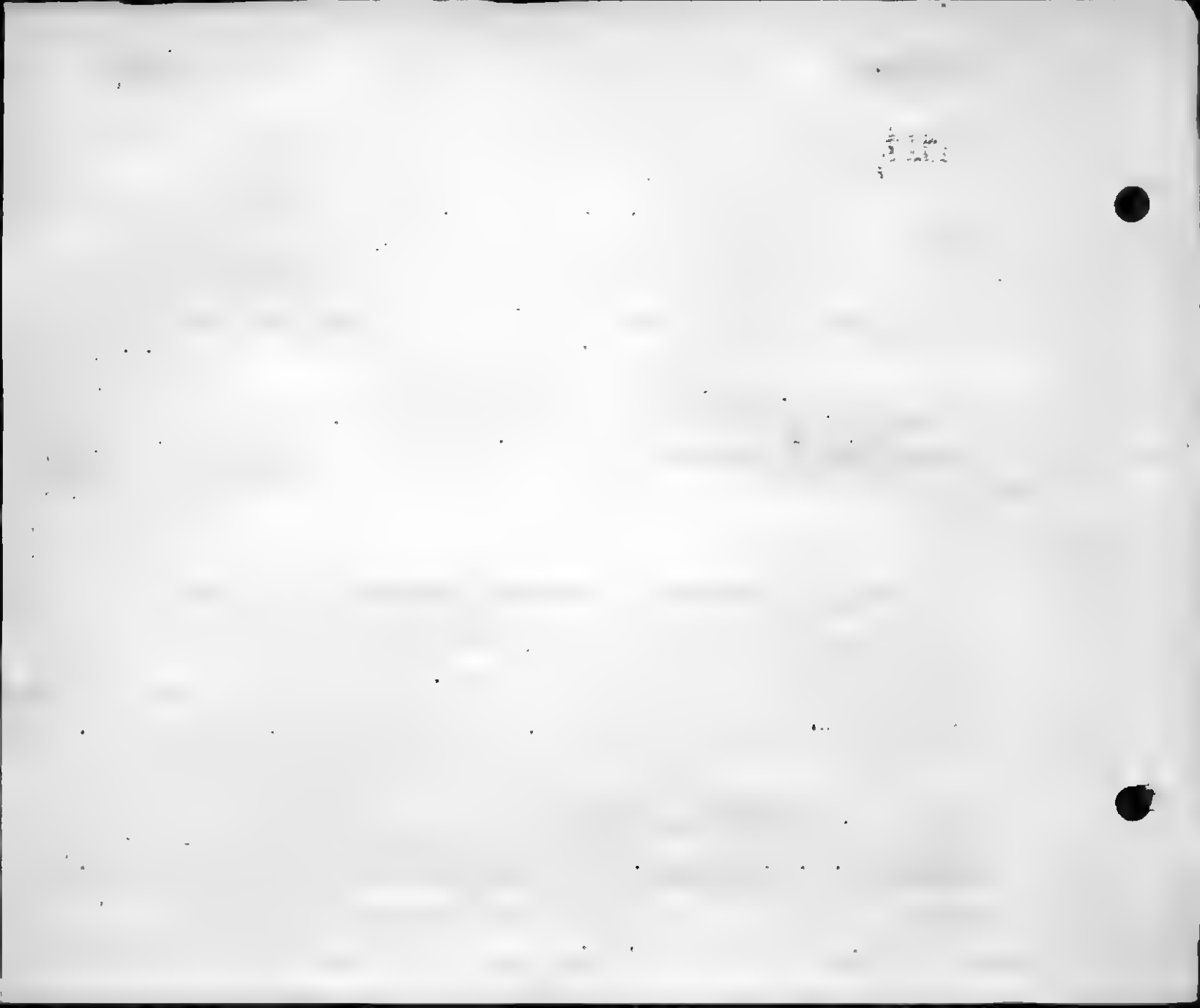
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04318

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Williamsport	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital D. O. A		d. STREET ADDRESS Mt. Tammany	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond Hershey Miller Jr.		4. DATE OF DEATH Month Day Year March 17 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23 1922
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days 2 21	11. IF UNDER 24 HRS. Hours Min. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Manager		10b. KIND OF BUSINESS OR INDUSTRY Lumber Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Raymond H. Miller Sr.		14. MOTHER'S MAIDEN NAME Edna Ankeney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220 16 0307	
17. INFORMANT Mrs. Marion Miller Williamsport, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull DUE TO (b) Fracture Cervical Vertebra (c) Fracture Right Femur (d) Compound Fracture Right Elbow PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car struck bridge abutment.	
20c. TIME OF INJURY Hour Minute 8:35 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. 81		20f. (City or town) (County) (State) Hagerstown, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-18-67 Address (Street, city, town, or county) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 20-67	22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport, Md.		24a. REC'D BY REGISTRAR MAR 22 1967 24b. REGISTRAR'S SIGNATURE Charles J. J.	



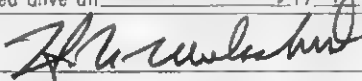
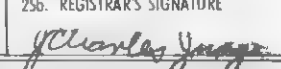


**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**04317**

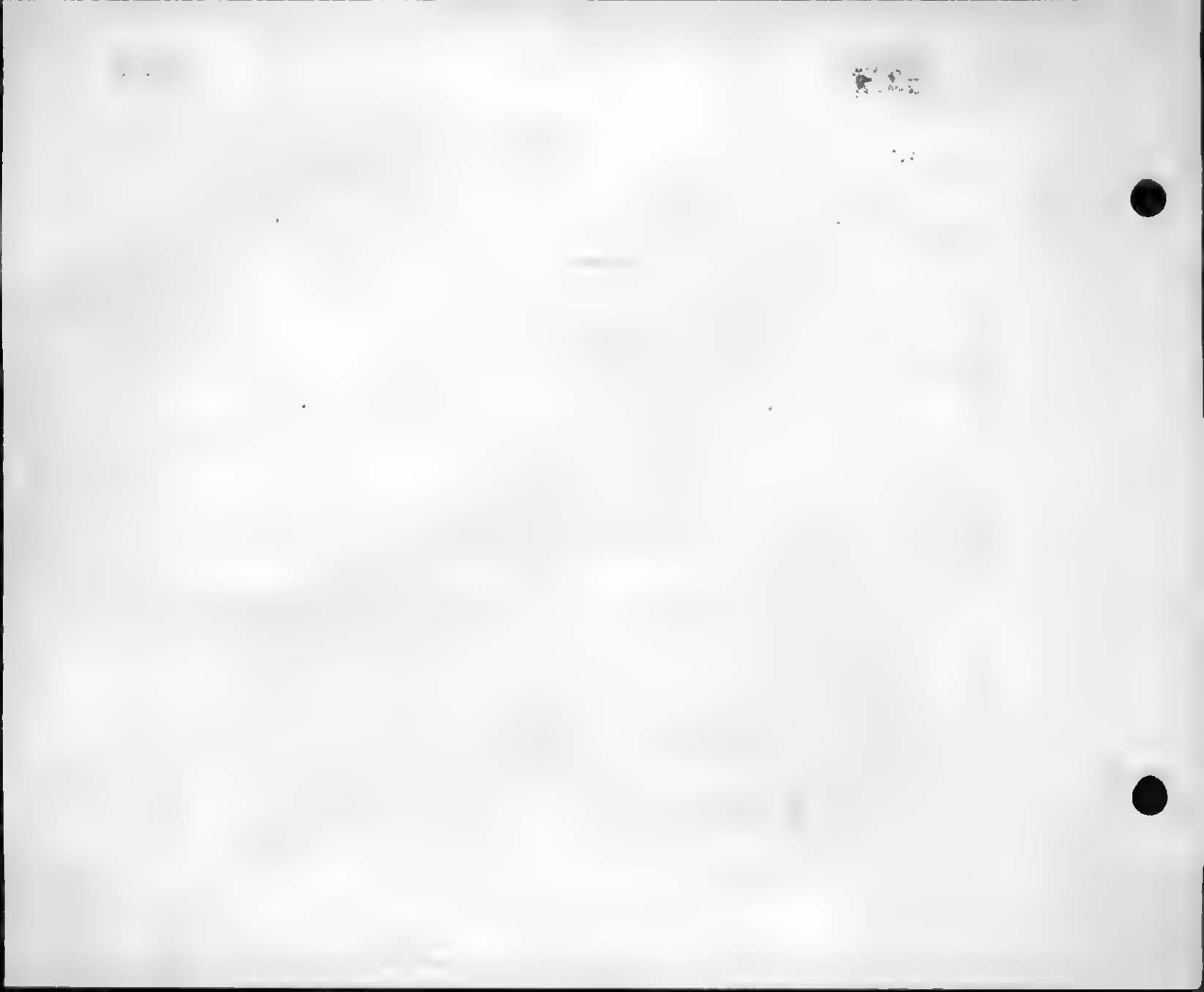
**CERTIFICATE OF DEATH**

**04319**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a STATE <b>Maryland</b> b COUNT <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN TB <b>46 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1030 Main Ave.</b>		e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Ellsworth</b> Last <b>Montgomery</b>				4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>67</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 26 1902</b>			
				9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Cabinet Shop</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Organ Mfg.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Keedysville Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>John F. Montgomery</b>				14. MOTHER'S MAIDEN NAME <b>Nannie F. Wade</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO <b>213-01-2401</b>		17. INFORMANT <b>Mrs. Grace Montgomery, Hagerstown</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Endotoxic shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute pyelonephritis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>sev. days</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic nephrosclerosis &amp; pyelonephritis; C.V.D.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>December 1960</b> , to <b>March, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 28, 1967</b> , and that death occurred at <b>5 A.M.</b> from causes and on the date stated above.									
22a. SIGNATURE 			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/28/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>			22d. ADDRESS <b>580 Northern Avenue Hagerstown, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-31-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Smithsburg, Maryland</b>			
24. FUNERAL DIRECTOR <b>Minich Funeral Home Hagerstown, Md</b>			ADDRESS <b>21746</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE 		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~within~~ <sup>within</sup> 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04318

CERTIFICATE OF DEATH

04320

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>1 West Wilson Blvd</b>	
3. NAME OF DECEASED (Type or print) <b>NANNIE PEARL MOSER-LUSHBAUGH</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 15 1885</b>
9. AGE (In years last birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Church Hill Fred Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Soule J. Warrenfeltz</b>		14. MOTHER'S MAIDEN NAME <b>Clara Palmer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-46-6139</b>	
17. INFORMANT <b>Lester Lushbaugh</b>		Address <b>1 West Wilson Blvd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>athrosclerotic heart disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January, 1958</b> , to <b>March, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 26 1967</b> , and that death occurred at <b></b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Howard N. Weeks</i>		22b. DATE SIGNED <b>3/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22d. ADDRESS <b>580 Northern Avenue Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md.</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		25. REC'D BY REGISTRAR <b>MAR 30 1967</b>	
25a. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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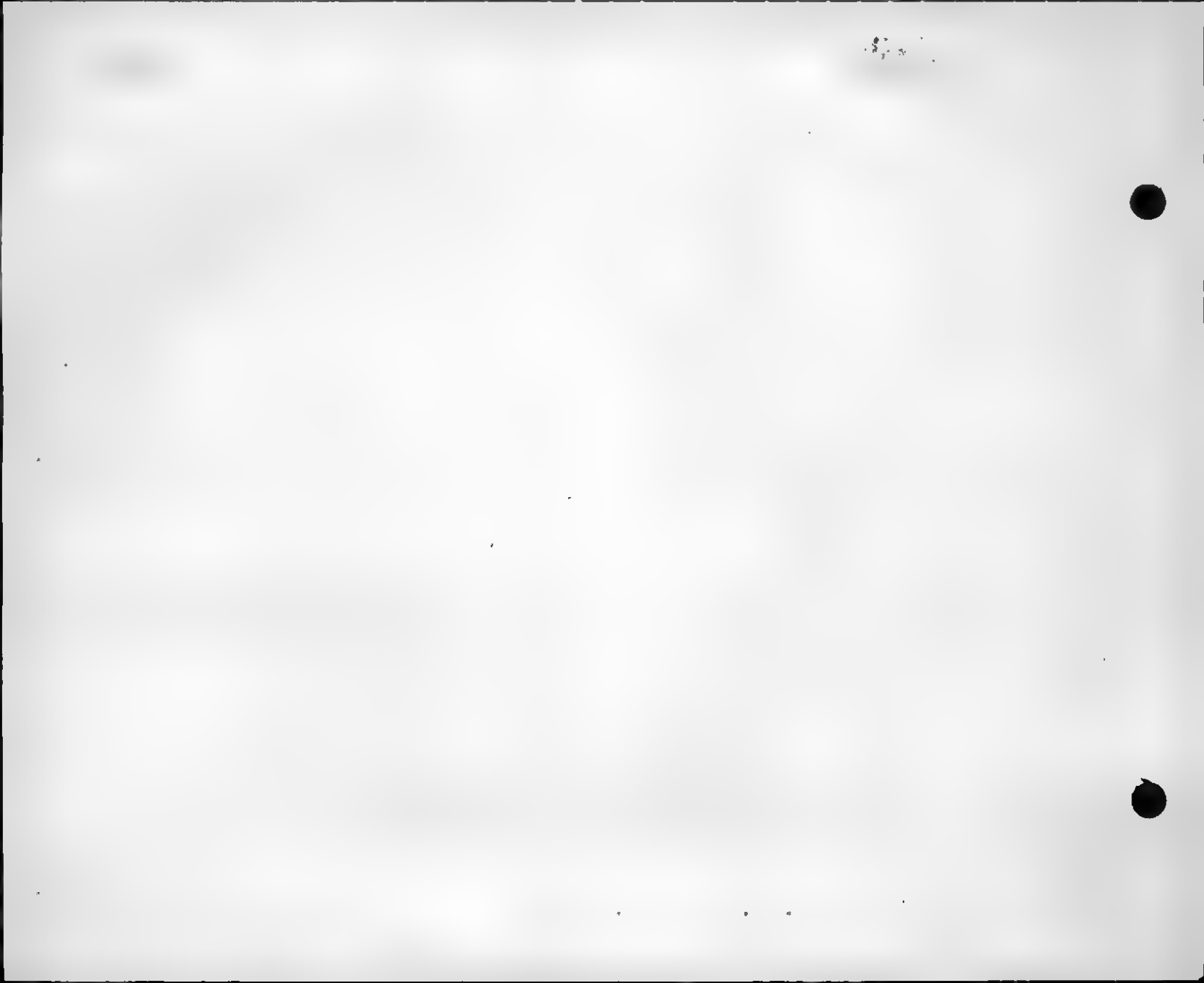
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04319

CERTIFICATE OF DEATH

04321

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>3 HRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>RURAL 1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES SIMMONS MUNSON</b>		4. DATE OF DEATH Month Day Year <b>3 19 19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 8 1880</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>HANCOCK MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W MUNSON</b>		14. MOTHER'S MAIDEN NAME <b>PLESANT SOMMONS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>NORMAN R MUNSON RURAL 1 HANCOCK MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pulmonary embolism</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>8 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>urinary tract infection severe</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-25</b> , 19 <b>66</b> to <b>3-19</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-19</b> , 19 <b>67</b> , and that death occurred at <b>6 P</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Joseph C. Crisp</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH C. CRISP</b>		22d. ADDRESS <b>580 Northern Ave Hagerstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3.23.67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>	23d. LOCATION (City or Town) (County) (State) <b>RURAL 1 HANCOCK WASHINGTON MD.</b>
24. FUNERAL DIRECTOR <b>Houssard &amp; Stone Hancock Md</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			



FUR. STAT.  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

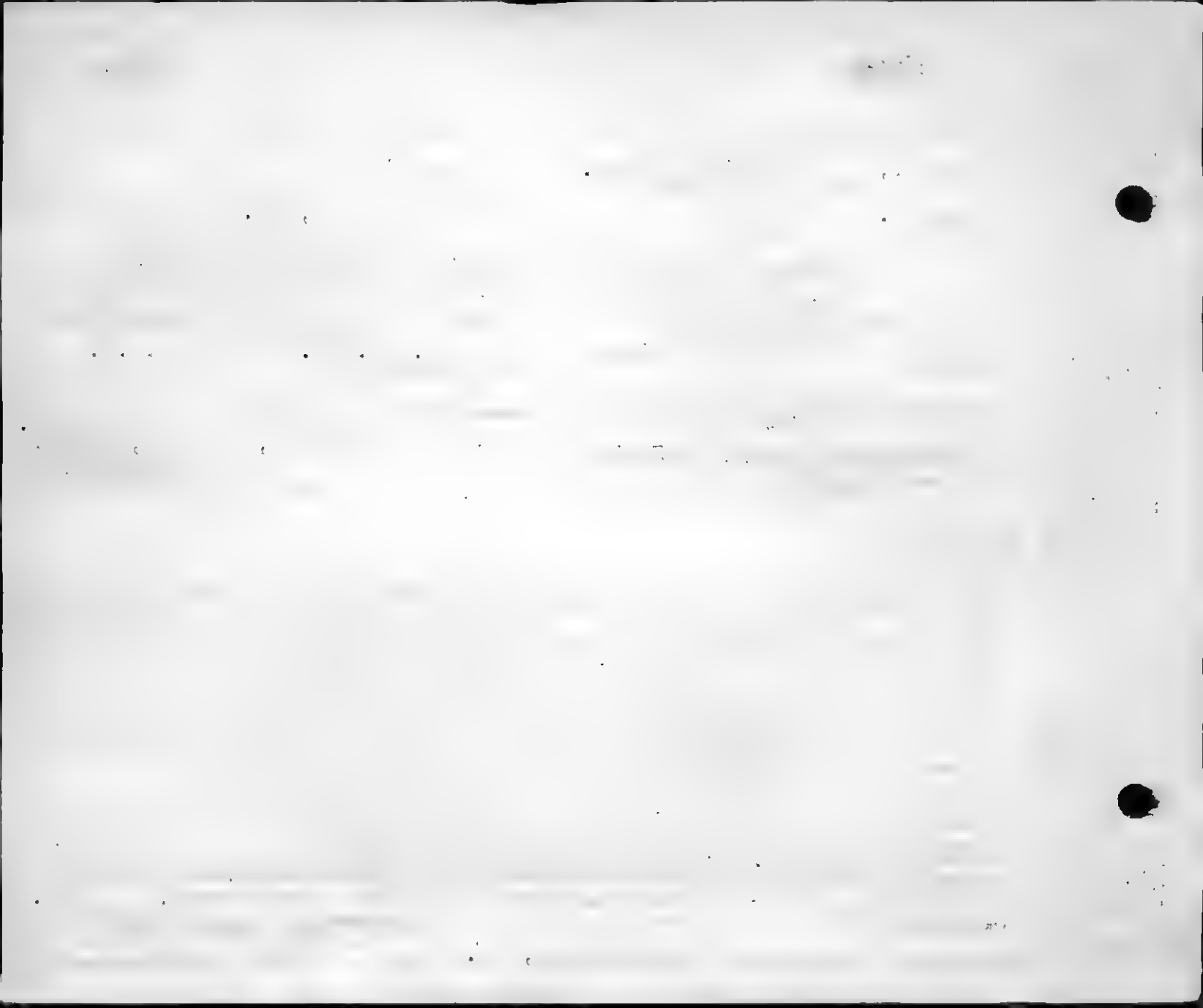
VR AISM  
5M 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04320

04322

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 1, Clear Spring 5 yrs.</b> c. LENGTH OF STAY IN 1b <b>5 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rural 1.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural 1</b> d. STREET ADDRESS <b>Clear Spring, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ralph Franklin Myers</b>		4. DATE OF DEATH Month Day Year <b>March 12 1967</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/23/21</b>		9. AGE (in years last birthday) <b>46 yrs.</b>		10. IF UNDER 1 YEAR Months Days <b>46</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Myers</b>				14. MOTHER'S MAIDEN NAME <b>Mazie Shank</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W W 2 215-26-1849</b>		17. INFORMANT <b>Mrs Genevieve Myers, Route 1, Clspg, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Penetrating gunshot wound of</b> <b>chest</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>chest</b> DUE TO (c) <b>chest</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Self inflicted gunshot of chest</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Self inflicted gunshot of chest</b>					
20c. TIME OF INJURY Month, Day, Year <b>3-12-1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Clear Spring Wash. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto III</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>3-14-67</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/15/67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR <b>Margaret Rawland</b>				24a. REC'D BY REGISTRAR <b>16 1067</b>			
				24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





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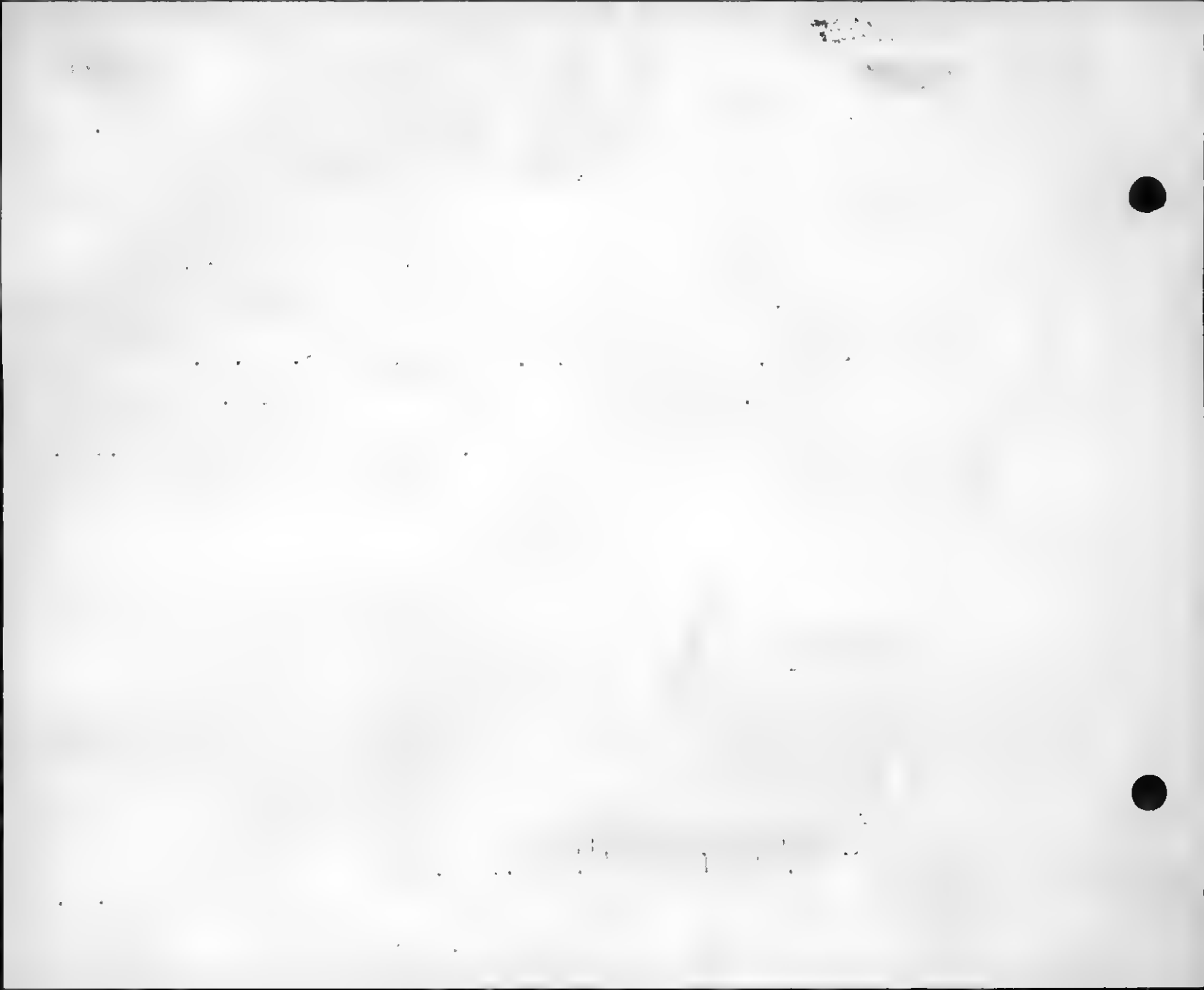
FOR STATE HEALTH DEPT.

04321

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04323

1. PLACE OF DEATH a COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Wash.</b>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hagerstown</b>			c LENGTH OF STAY IN b <b>1 1/2 years</b>			c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown rural</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d STREET ADDRESS <b>RFD 6</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FRANK</b> Last <b>PENNINGTON</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1967</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-24-1912</b>	
9. AGE (In years last birthday) <b>54</b> yrs		10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plastics dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>aircraft mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Jefferson Co., W.Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Frank B. Pennington</b>			
14. MOTHER'S MAIDEN NAME <b>Emma V. Collis</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO <b>232-28-2688</b>				17. INFORMANT <b>Mrs. Kathryn Pennington, Hag., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured berry aneurysm of left middle cerebral artery</b> DUE TO <b>Intracerebral hemorrhage of temporal lobe and insula on left side</b> Conditions favoring which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Massive subarachnoid hemorrhage 2ndary hemorrhage into midbrain</b> (c) <b>Coronary atherosclerosis with old myocardial infarction. Cardiac hypertrophy</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary atherosclerosis with old myocardial infarction. Cardiac hypertrophy</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell in driveway at home - Struck Head</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>4:45</b> pm <b>3-6-1967</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) (County) (State) <b>Morgansville Wash Md</b>				21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
22. DATE SIGNED <b>3-8-67</b>				23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) <b>217 W. WASHINGTON ST. HAG., MD.</b>			
24. ACTUAL SIGNATURE <b>Edward E. Ditto III</b>				25. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>			
26. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				27. DATE THEREOF <b>3-11-67</b>		28. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>	
29. LOCATION (City or Town) (County) (State) <b>Shepherdstown, W.Va.</b>				30. REC'D BY REGISTRAR <b>MAR 13 1967</b>			
31. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				32. REGISTRAR'S NAME <b>Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

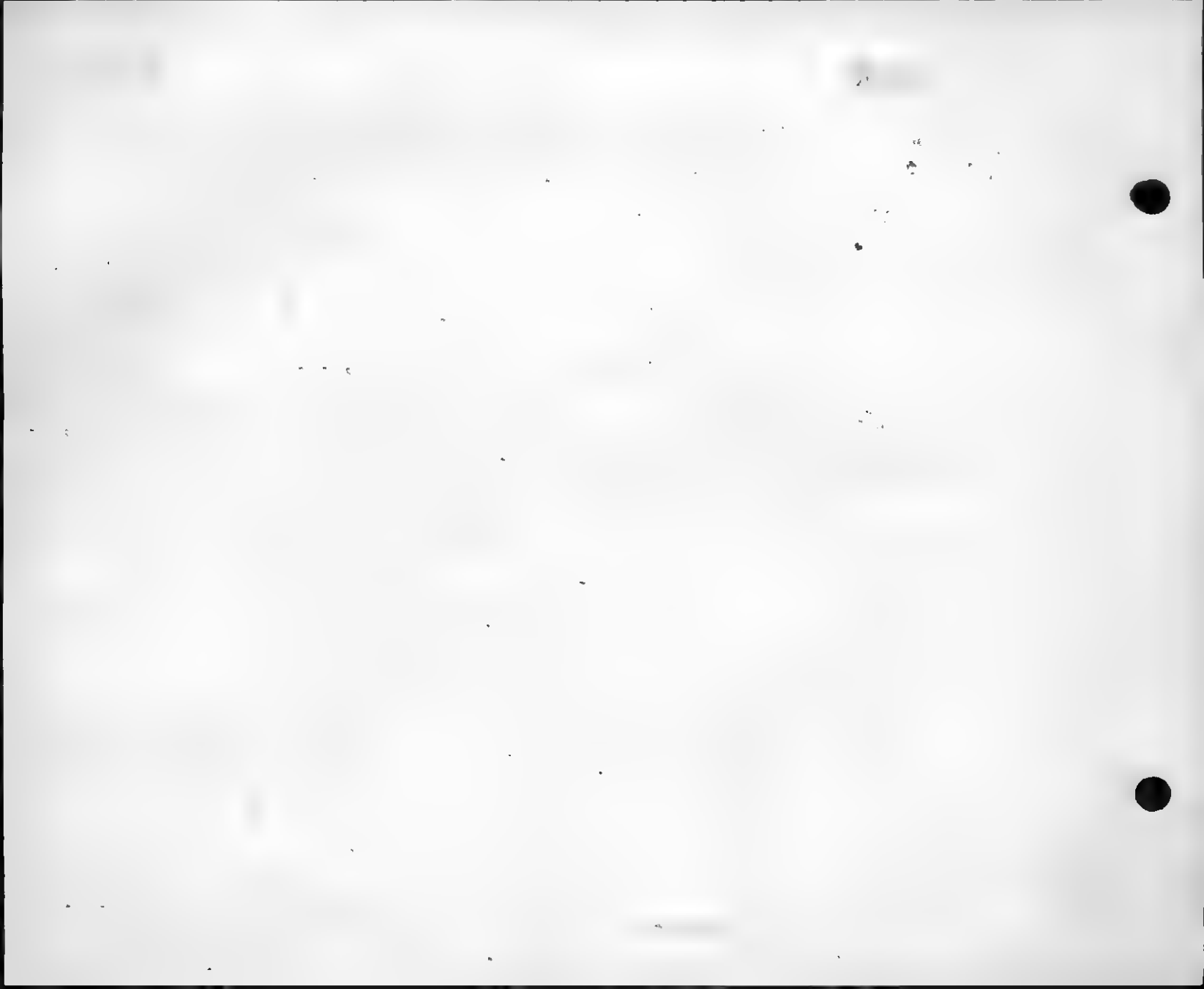
04322

04324

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>21 yrs.</u>		d. STREET ADDRESS <u>132 Dogwood Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Pittinger</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Jarrytown, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dennis Bannon</u>		14. MOTHER'S MAIDEN NAME <u>Catherine O'Connor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>074-22-57957</u>	
17. INFORMANT <u>Mrs. Margaret Reif</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized atherosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Severe sinus degeneration</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1967</u> , to <u>Mar 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 14, 1967</u> , and that death occurred at <u>3:07 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>L. L. Packer Jr M.D.</u>		22b. DATE SIGNED <u>3/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer Jr M.D.</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. A. Mont</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		DATE <u>MAR 16 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

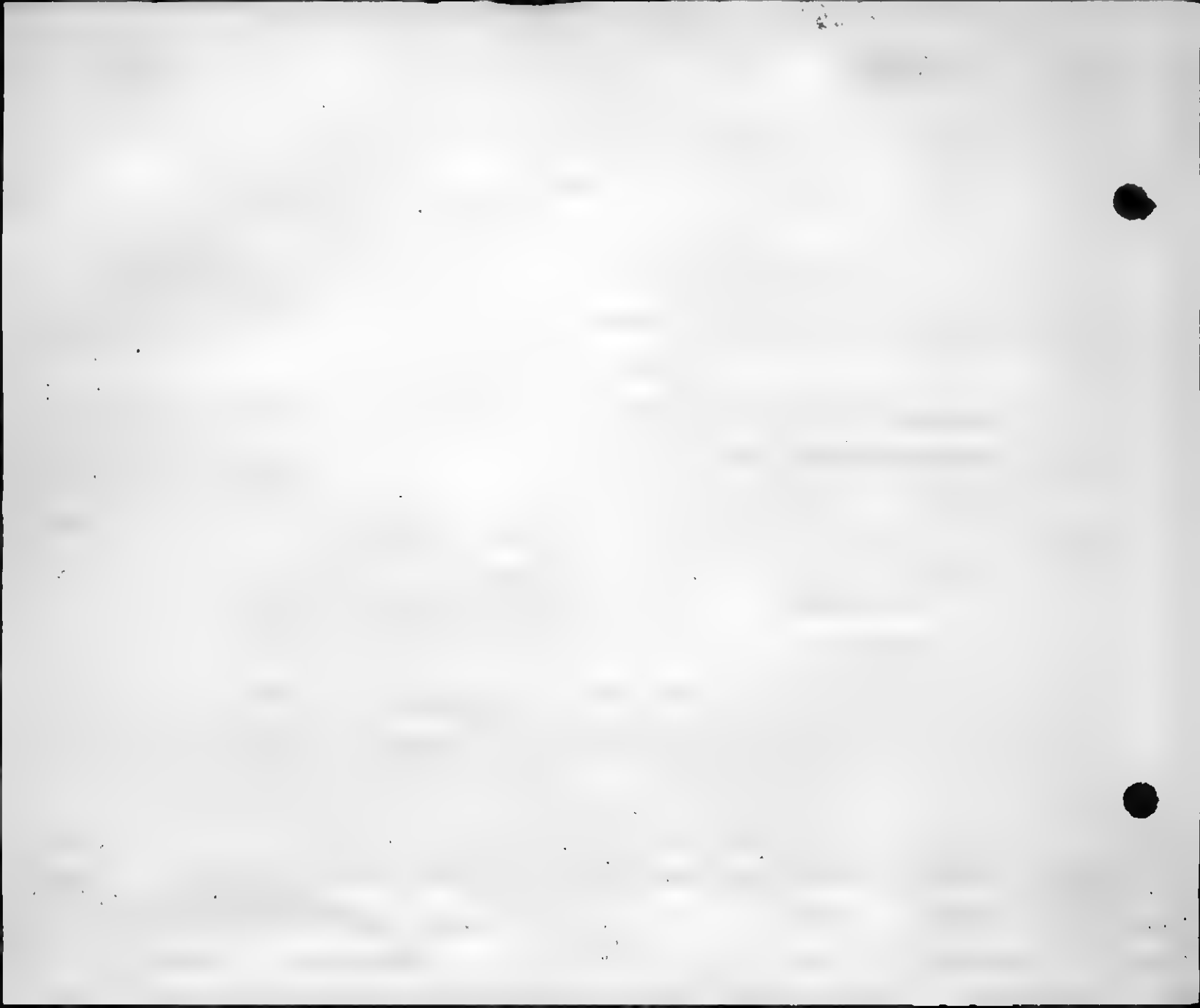
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04325

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in 1b 1 day		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport		d. STREET ADDRESS 114 W. Salisbury Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Alice Middle Hoffman Last Poole		4. DATE OF DEATH Month March Day 31 Year 19 67		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 10 1911		9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 11 Days 20		11. IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A											
13. FATHER'S NAME Charles G. Poole								14. MOTHER'S MAIDEN NAME Sadie Elizabeth Crowell															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220 18 1047				17. INFORMANT 138 W Address Washington St. Mr. David K. Poole Jr. Hagerstown, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypercalcemia incidental to DUE TO anemia due chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO pyelonephritis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														INTERVAL BETWEEN ONSET AND DEATH 3-6 days 5-10 yrs									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
21a. SIGNATURE Edward W. Ditto III				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4-1-67							
21b. EXAMINER'S NAME (Type) Edward W. Ditto III Hagerstown, Maryland				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 3-67				22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery				22d. LOCATION (City, town, or county) (State) Williamsport Maryland											
23. FUNERAL DIRECTOR Albert L. Leaf Williamsport Maryland								24a. REC'D BY REGISTRAR APR 1 1967								24b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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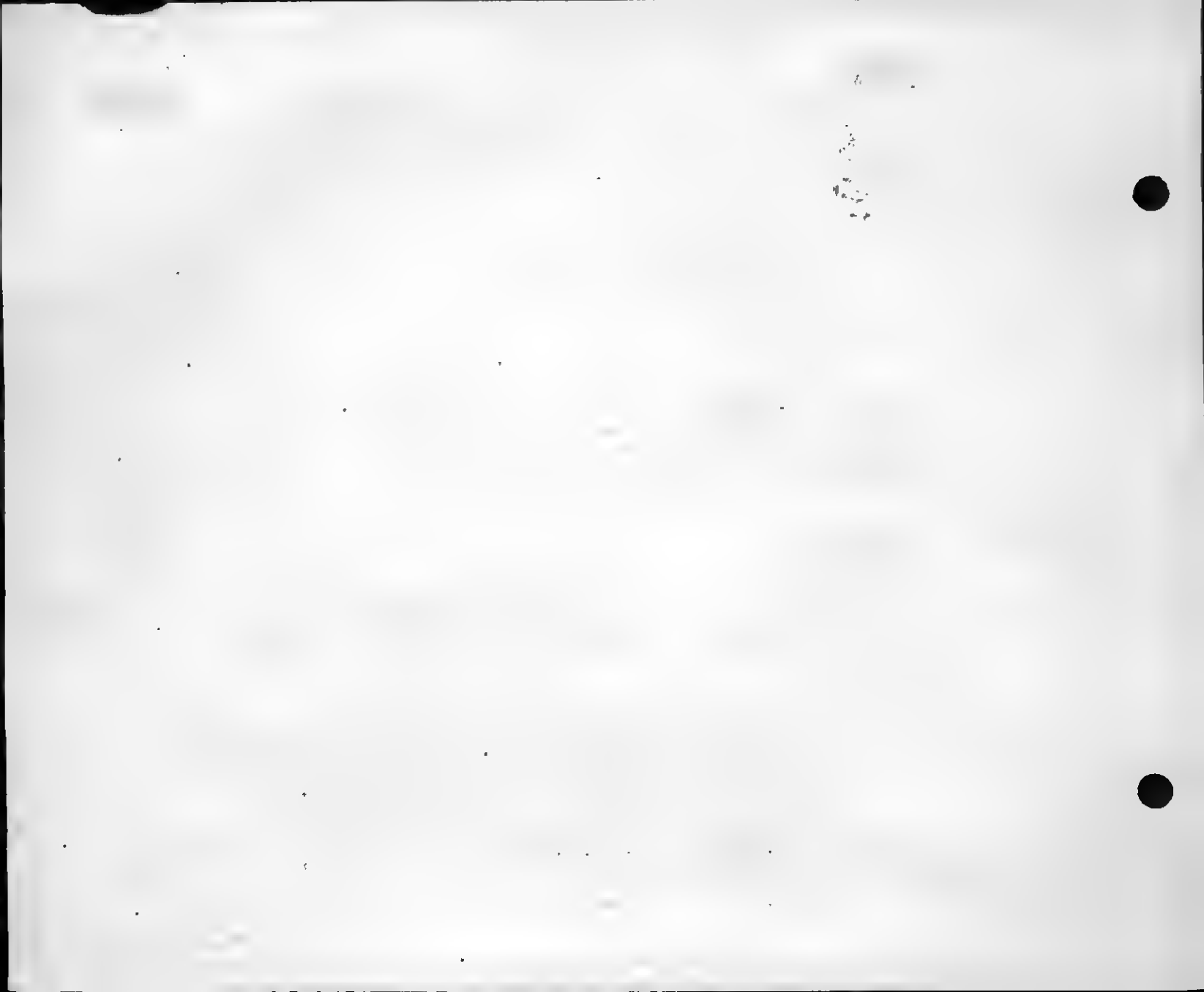
VR A15 (4)  
MO M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04324

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution resident, give institution name) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>45 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>909 Forest Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Percy Joseph Potter</b>		4. DATE OF DEATH Month Day Year <b>March 4 1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-17-1879</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>vice president</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>sand blast mfg.</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Stratford on Avon Eng.</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>Frederick K. Potter</b>		15. MOTHER'S MAIDEN NAME <b>Susan A. Rutter</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>214-09-6087</b>	
18. INFORMANT <b>Mary Potter</b>		Address <b>Hagerstown, Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Pulmonary embolism with infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Thrombosis right iliac vein</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease with auricular fibrillation and heart block</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>Feb. 21</b> , 19 <b>67</b> , to <b>March 4</b> , 19 <b>67</b> that (we) last saw the deceased alive on <b>March 3</b> , 19 <b>67</b> , and that death occurred at <b>5:15 A.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>3/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington St. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>3-6-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 9 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





04325.

## CERTIFICATE OF DEATH

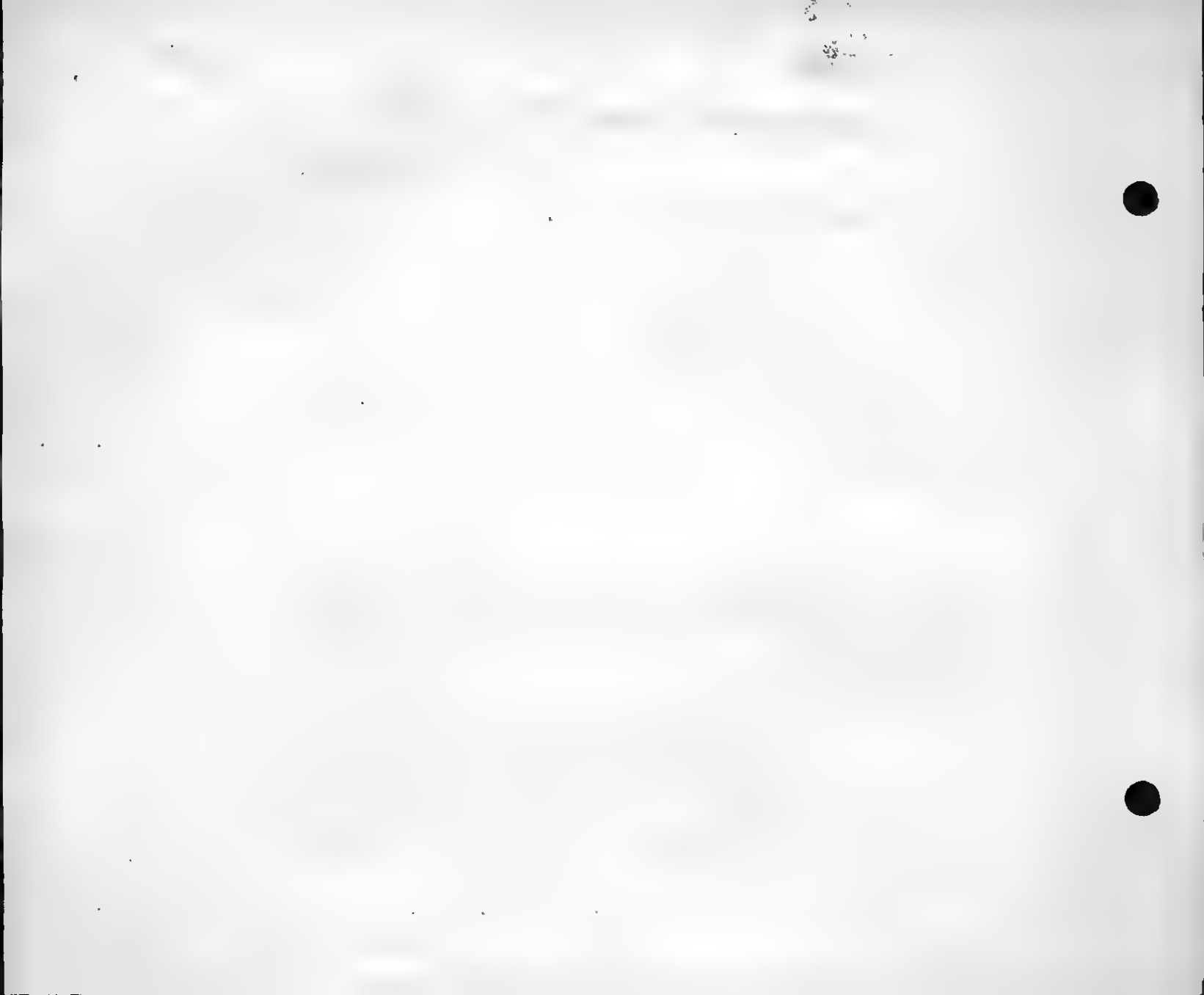
04327

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
 25M 1/67

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if inst tution before admission) a. STATE <b>Md</b> b. COUNTY <b>Cal.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Sunderland - Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Maryland State Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>R</b> Last <b>Reed</b>		4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-1900</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of work, no life, even if retired) <b>Labor</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Dennis Reed</b>	
14. MOTHER'S MAIDEN NAME <b>Christine Thomas</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <b>218-12-9241</b>		17. INFORMANT <b>Lionia Reed</b> Address <b>Friendship AA. Co.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Lobar pneumonia</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Arteriosclerosis, General</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>4 years</b> <b>UNKNOWN</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pyelonephritis</b>		19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-9</b> , 19 <b>66</b> , to <b>3-27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-26</b> 19 <b>67</b> , and that death occurred at <b>5:30</b> AM, from causes and on the date stated above			
22a. SIGNATURE <b>Maxwell</b>	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>3-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEVARDO LAYZEGUILLA</b>	22d. ADDRESS <b>1500 PENNA. AVE. HAGERSTOWN, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-31-67</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Ch. Cem.</b>	23d. LOCATION (City or town) (County) (State) <b>Sunderland Cal. Md</b>
24. FUNERAL DIRECTOR <b>Pinkney E. S. ...</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04326

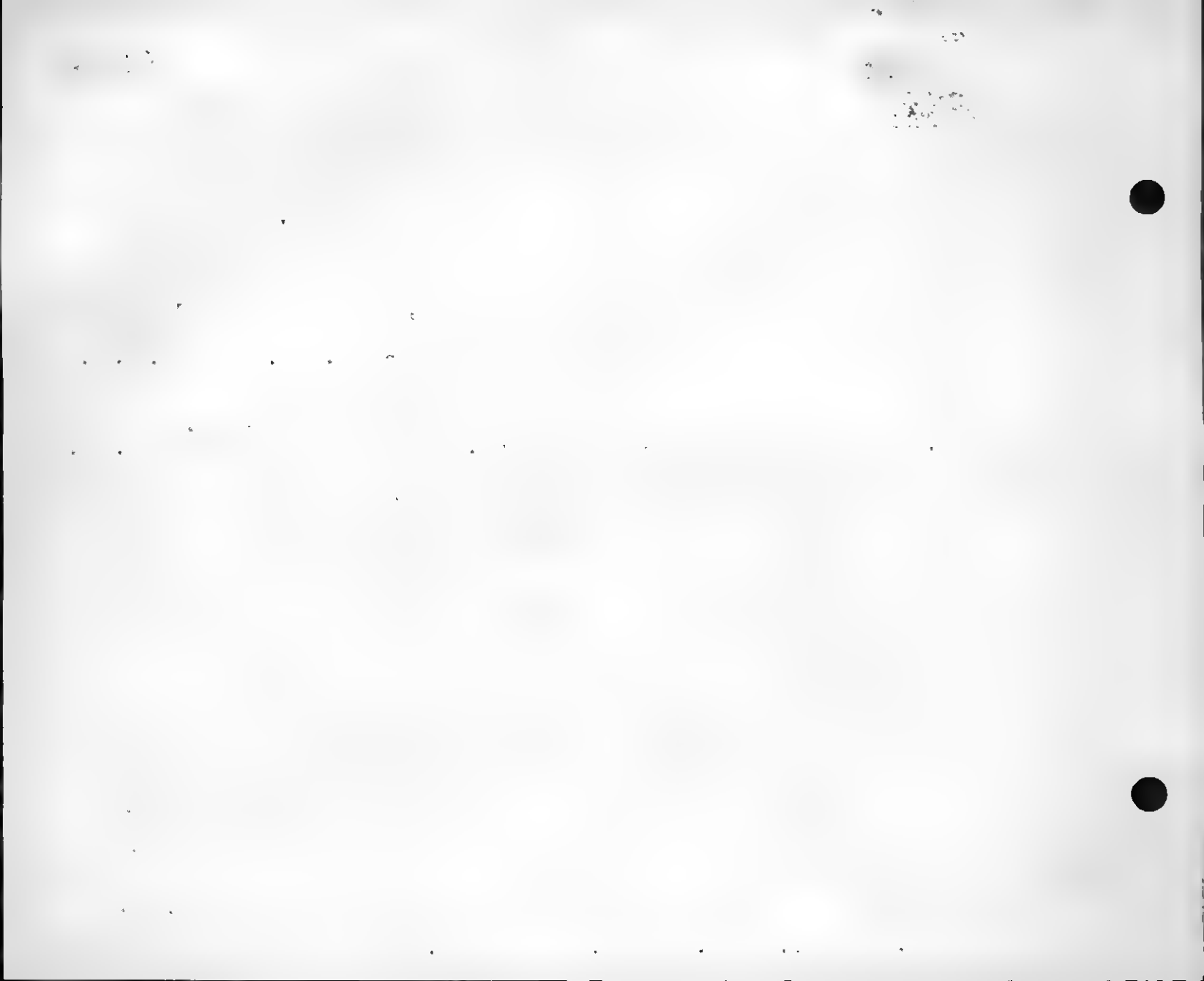
CERTIFICATE OF DEATH

04328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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M

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>		c. LENGTH OF STAY IN TOWN <u>2 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reeder Nursing Home</u>				d. STREET ADDRESS <u>620 Chestnut St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Elizabeth</u> Last <u>Reeder</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> , Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1870</u>	9. AGE (In years lost birthday) <u>96</u> yrs	IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lewis Shank</u>				14. MOTHER'S MAIDEN NAME <u>Ella Alexander</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO <u>220-52-2108</u>		17. INFORMANT <u>726 Maryland Ave. Mrs. Goldie Henninger, Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Interoskeletal cardio vasculon</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>67</u> , to <u>March 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> , 19 <u>67</u> , and that death occurred at <u>11 P.</u> M. from causes and on the date stated above							
22a. SIGNATURE <u>G. W. Levan</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 15, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>G. W. Levan</u>		22d. ADDRESS <u>Boonsboro, Md.</u>					
23a. BURIAL, CREMATION, or other disposal <u>Burial</u>		23b. DATE THEREOF <u>3-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Locust Grove, Md.</u>	
24. FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>				25. DATE BY REGISTRAR <u>MAR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04327

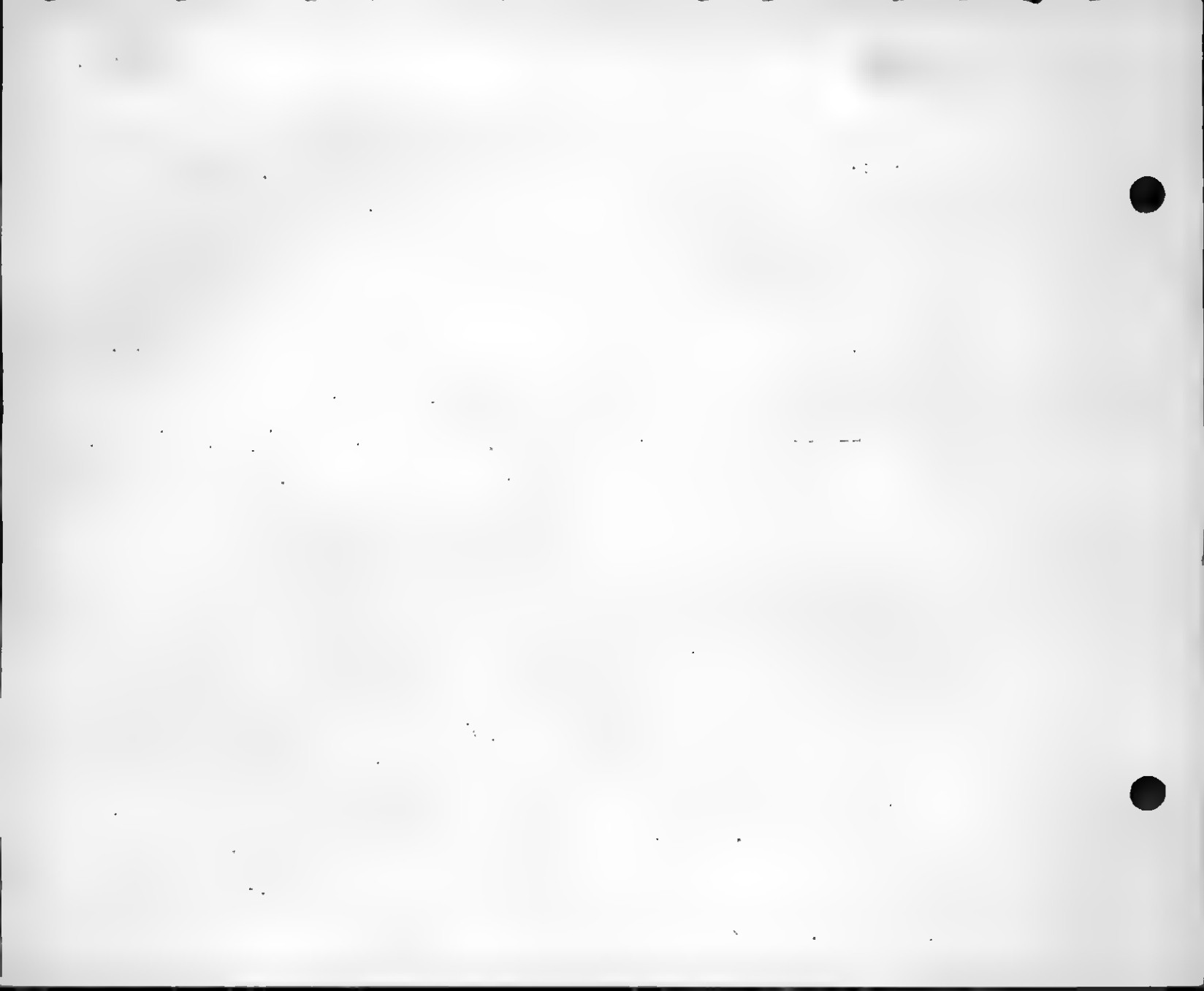
CERTIFICATE OF DEATH

04329

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>13 Hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>231 South Locust St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WILLIAM REMSBURG Sr</u>				4. DATE OF DEATH Month Day Year <u>March 28 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27 1886</u>		9. AGE (In years last birthday) yrs <u>80</u>	10. IF UNDER 1 YEAR Months Days Hours Min <u>0 0 0 0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chewsville Wash Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph H. Remsburg</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Young</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. etc.) <u>No</u>		16. SOCIAL SECURITY NO <u>219-14-9819</u>		17. INFORMANT <u>Clayton I. Remsburg</u>		Address <u>Frederick Md</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced atherosclerosis</u> 45000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>dehydration - cachexia</u> DUE TO (c)				204 Crestview Court INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <u>3/28 1967</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> , 19 <u>67</u> , to <u>3/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> , 19 <u>67</u> , and that death occurred at <u>4 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>A. M. Mandell</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3/30/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. M. MANDELL, M.D.</u>		22d. ADDRESS <u>119 E. Antietam St.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman</u>				25a. REC'D BY REGISTRAR DATE <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	









MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04329

CERTIFICATE OF DEATH

04331

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN TB <b>43 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>136 N. POTOMAC STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>NORMA NMI RIGGIN</b>		4 DATE OF DEATH Month Day Year <b>MARCH 30 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 9 1894</b>
9 AGE (In years last birthday) <b>72 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGISTERED NURSE</b>	11. BIRTHPLACE (County & State, or foreign country) <b>FLINT HILL VIRGINIA</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWIN RAMEY</b>	
14. MOTHER'S MAIDEN NAME <b>ALBENIA PAYNE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>216-46-8891</b>		17. INFORMANT <b>WILLIAM C RIGGIN 136 N. POTOMAC ST. HAGERSTOWN MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia &amp; uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Generalized metastasis</b> DUE TO (c) <b>Adenocarcinoma of stomach</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>6 mos</b> <b>2 yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>none 19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) (County) (State) <b>- - -</b>
21. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>Sept</b> , 19 <b>61</b> , to <b>Mar 30</b> , 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Mar 30</b> , 19 <b>67</b> , and that death occurred at <b>3 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>H.R. Tritch Jr MD</i>		22b. DATE SIGNED <b>3/31/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>H.R. TRITCH JR. M. D.</b>		22d. ADDRESS <b>302 N. POTOMAC ST. HAGERSTOWN MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASHINGTON MD.</b>
24 FUNERAL DIRECTOR <b>CHARLES M ROUZER HAGERSTOWN MARYLAND</b>		25a. REC'D BY REGISTRAR <b>APR 5 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Juzar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and infant, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04330

CERTIFICATE OF DEATH

04332

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if at institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>5 Hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>oller Apts</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ALBERTA</b> Last <b>RITCHIE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 7 1870</b>
9. AGE (In years last birthday) <b>96</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Va. Purcellville Loudon Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Alder</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Myers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Mary Helen James Moller Apts</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4. Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Intermittent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 weeks</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obstructive jaundice - cause unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-3, 1967</b> , to <b>3-3, 1967</b> , that (I) (we) last saw the deceased alive on <b>3-3-1967</b> , and that death occurred at <b>11 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John H. Hornbaker, M.D.</b>		22b. DATE SIGNED <b>3-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 W. Washington St. Hagerstown, Md. 21740</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/6/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home</b>		25. REC'D BY REGISTRAR <b>MAR 8 1967</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

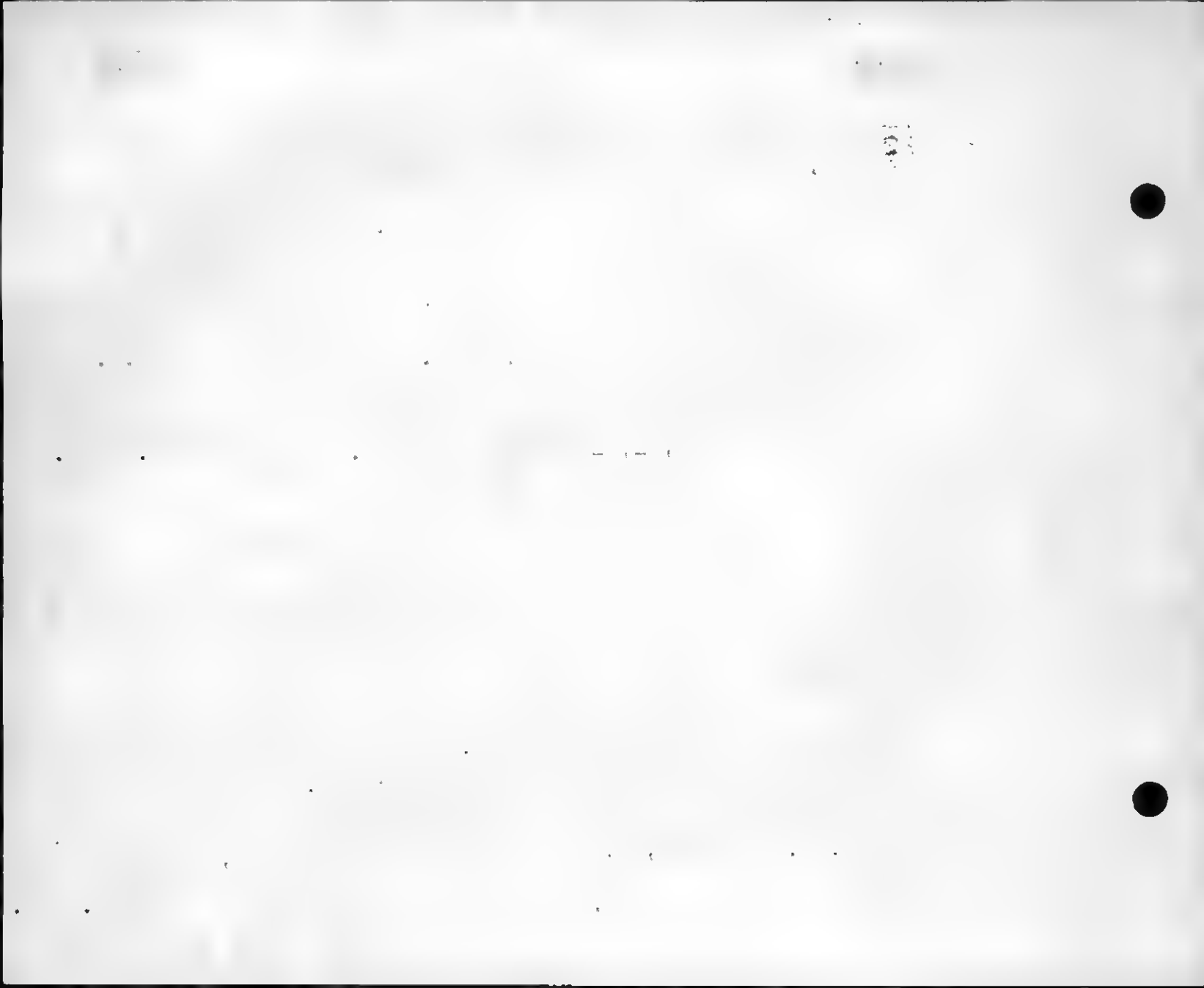
04331

CERTIFICATE OF DEATH

04333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and kept as a permanent record of the event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN TB <b>20 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>RT. #1</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>RICHARD VIRL ROBINSON</b>				4 DATE OF DEATH Month Day Year <b>MARCH 2 1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/1913</b>		9. AGE (In years last birthday) <b>54 yrs</b>	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE EQUIP. CORP.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>DAVID FILMORE ROBINSON</b>			
14. MOTHER'S MAIDEN NAME <b>MARY FAITH</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>213-16-0139</b>				17. INFORMANT Address <b>MRS. EDNA M. ROBINSON RT. #1 MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bilateral lobular pneumonia</b> 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic hepatic cirrhosis Laennec type</b> (c) <b>with ascites</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Known 2 months</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A T.O.P.S. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 29, 1966</b> to <b>March 2, 1967</b> (that (I) (we) lost saw the deceased alive on <b>March 1, 1967</b> , and that death occurred at <b>3:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>B. B. Kneisley</i>				22b. DATE SIGNED <b>3/3/67</b>		22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>	
22d. ADDRESS <b>148 West Washington St. Hagerstown, Maryland</b>				23a. BURIAL, CREMATION, REINTERMENT <b>BURIAL</b>			
23b. DATE THEREOF <b>3/4/67</b>				23c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>RINGOLD WASH. MD.</b>	
24. FUNERAL DIRECTOR <i>W. J. Normant Hagerstown Md.</i>				25a. REC'D BY REGISTRAR DATE <b>MAR 6 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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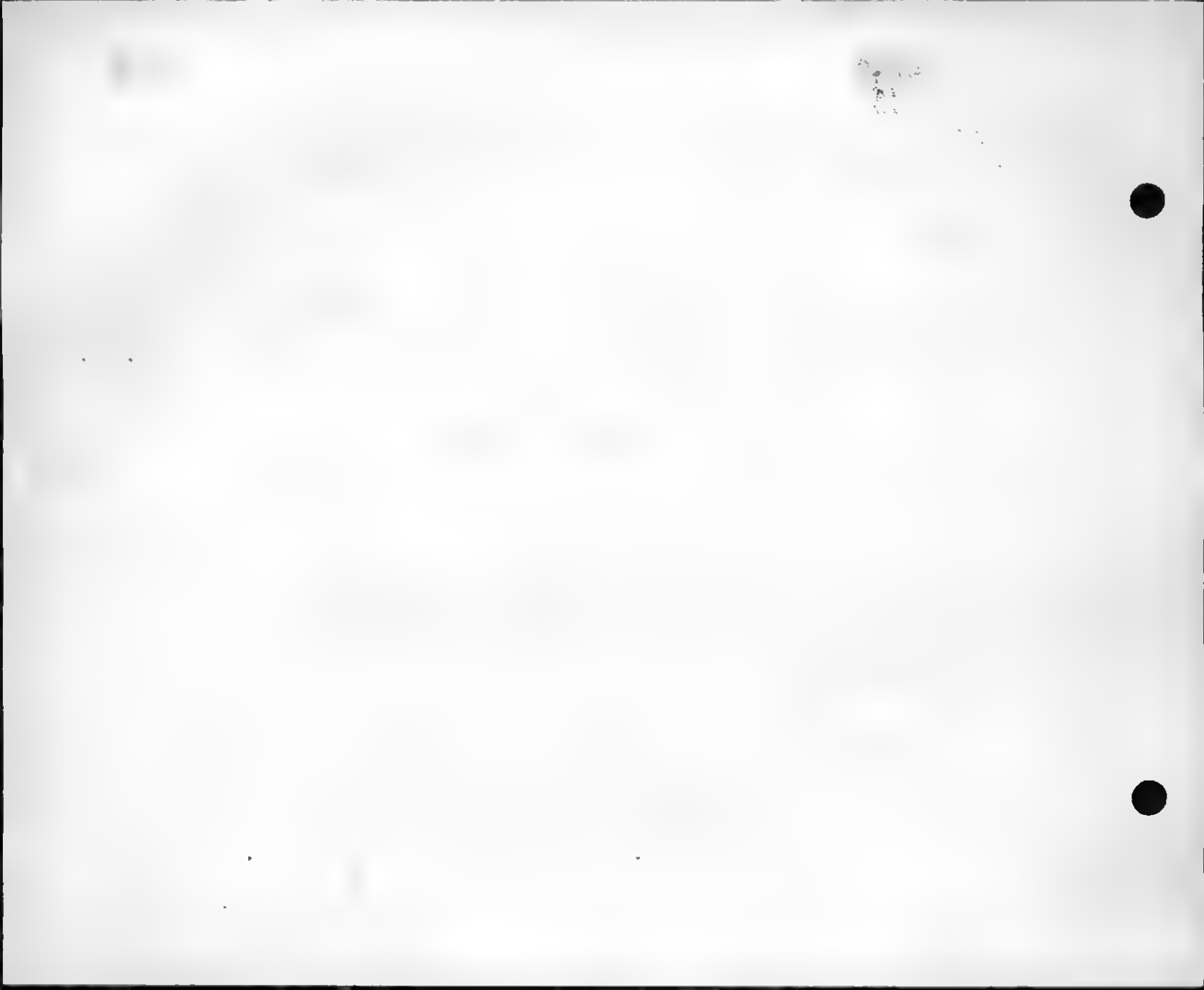
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04332

CERTIFICATE OF DEATH

04334

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>47 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>15 CYPRESS STREET</b>		d. STREET ADDRESS <b>15 CYPRESS STREET</b>	
3. NAME OF DECEASED (Type or print) <b>JOHNNIE McCULLEN ROE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 24, 1894</b>
9. AGE (in years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOOR MFG.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>TALBOT CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES A. ROE</b>		14. MOTHER'S MAIDEN NAME <b>CLARA STUPES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>214-09-5886</b>	
17. INFORMANT <b>MRS. RUTH ROE</b>		18. ADDRESS <b>15 CYPRESS STREET</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Extensive coronary artery disease</b> (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dissecting aortic aneurysm</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1965</b> , to <b>5 March, 1967</b> , that (I) (we) last saw the deceased alive on <b>26 Feb. 1967</b> , and that death occurred at <b>197</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John C. Stauffer</b>		22b. DATE SIGNED <b>3/7/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. STAUFFER M.D.</b>		22d. ADDRESS <b>145 S. PROSPECT ST. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MARCH 8, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, MARYLAND</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1967</b>	
ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



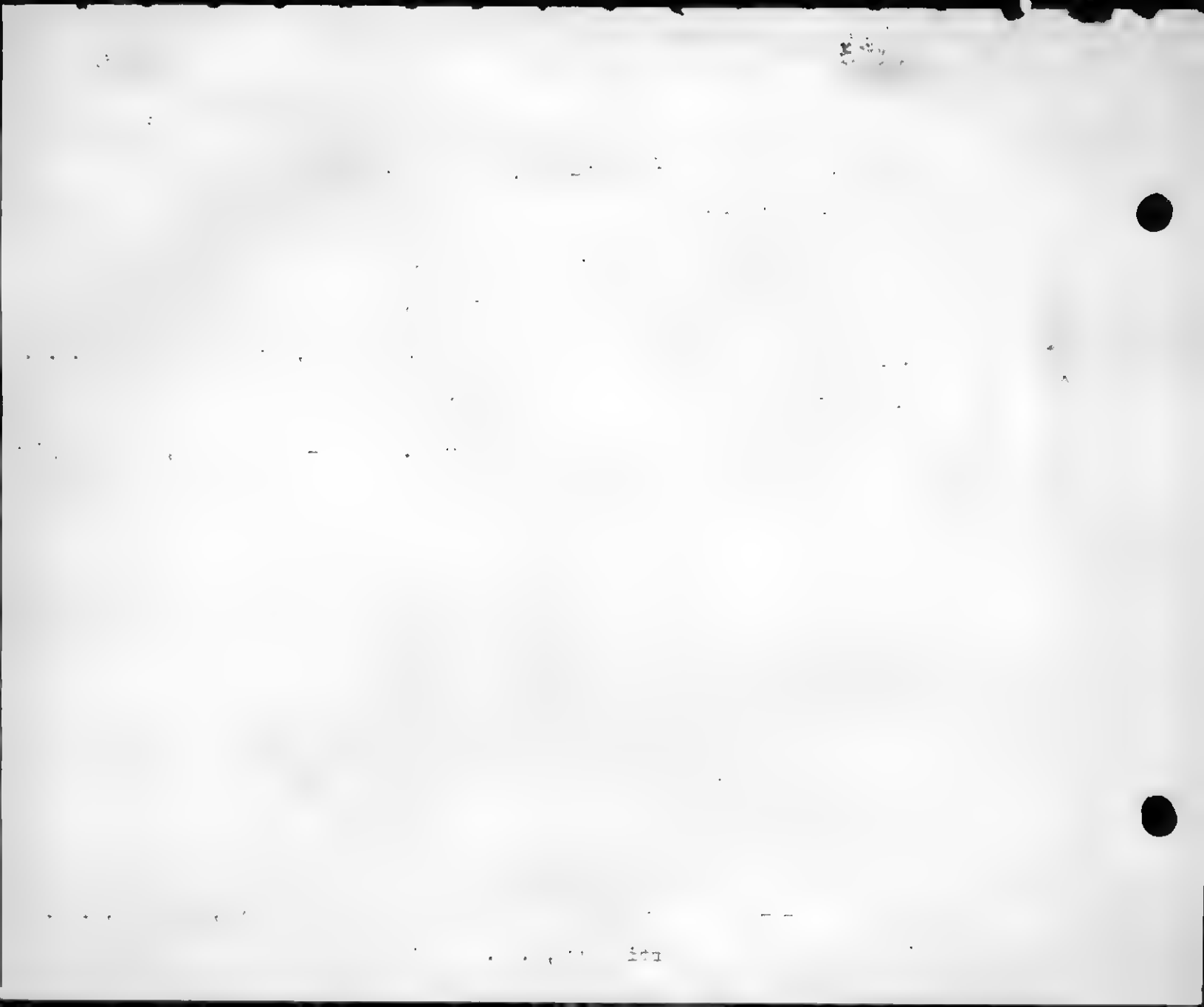


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b> c. LENGTH OF STAY IN 1b <b>1 month-3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Williamsport Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>22 Elizabeth Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rosie</b> Middle <b>May</b> Last <b>Romesburg</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pleasant Valley, Maryland</b>
13. FATHER'S NAME <b>Wesley Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Mary Belle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Melvin E. Ashton-Martinsburg, West Virginia</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> DUE TO (b) <b>Arteriosclerosis of uncertain cause</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January, 1967</b> , to <b>March, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 1, 1967</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles J. Judge</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles J. Judge</b>		22d. ADDRESS <b>M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-5-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Martinsburg, Berkeley, W. Va.</b>
24. FUNERAL DIRECTOR <b>Edward K. Brown</b> <b>Brown Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAR 13 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

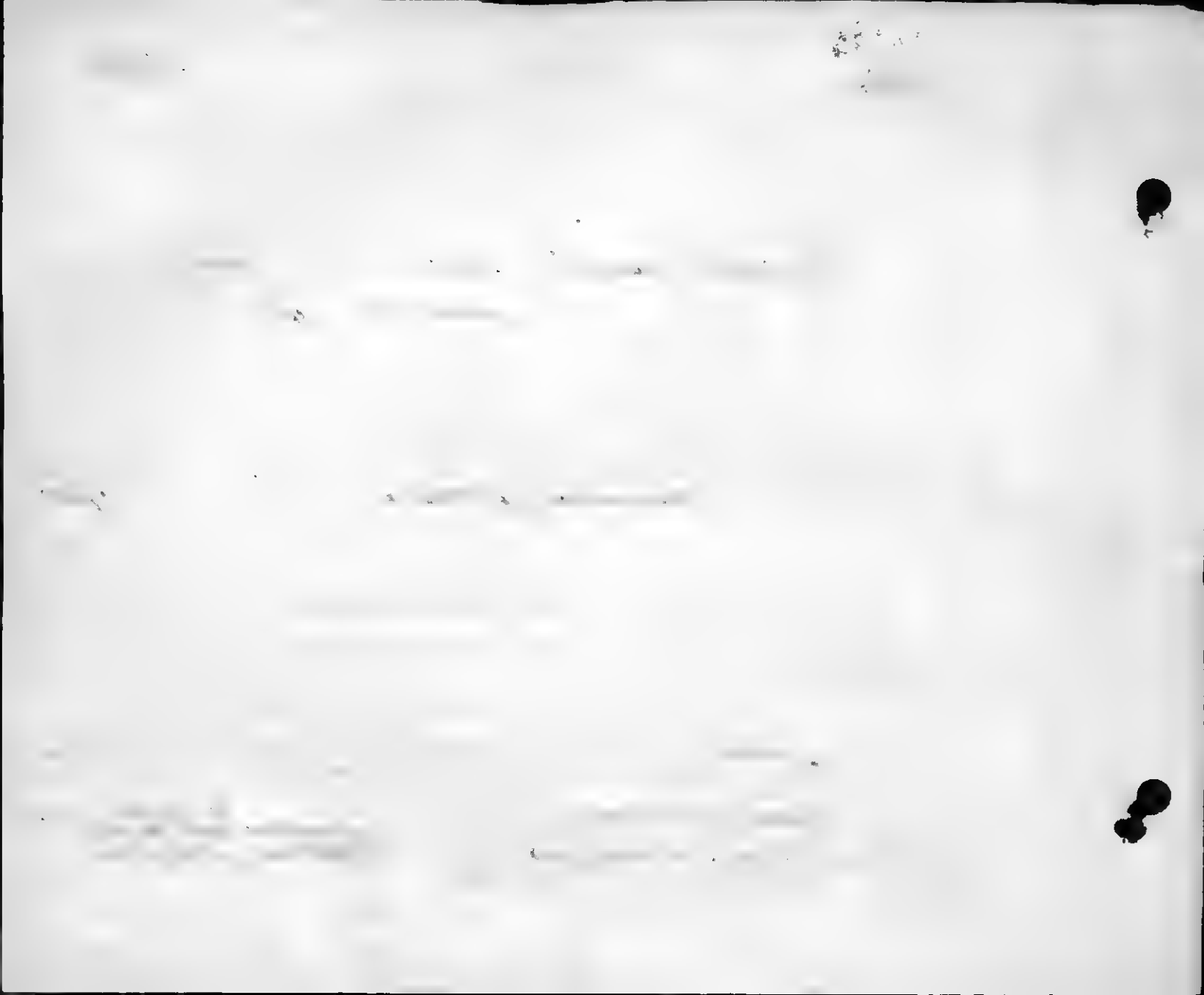
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04334

04336

1 PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in lb 3 Mos		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Maryland State Hosp.				d. STREET ADDRESS 418 Fremont St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Leucritia Ross		First Middle Last		4. DATE OF DEATH March 1, 1967		Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1917		9. AGE (In years last birthday) 49 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pa. Myersdale Somerset Co		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Calvin Holiday				14. MOTHER'S MAIDEN NAME Clara C. Hatton					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, up, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Lester W. Ross		Address 418 Fremont St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of cervix</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 1-16-67, 1967, to 3-1, 1967, that (1) (we) last saw the deceased alive on 2-28 1967, and that death occurred at 1A M, from causes and on the date stated above.									
22a. SIGNATURE Victor L. Ramos, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 1, 1967			
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.				22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/4/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Mdo			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR DATE MAR 3 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04335

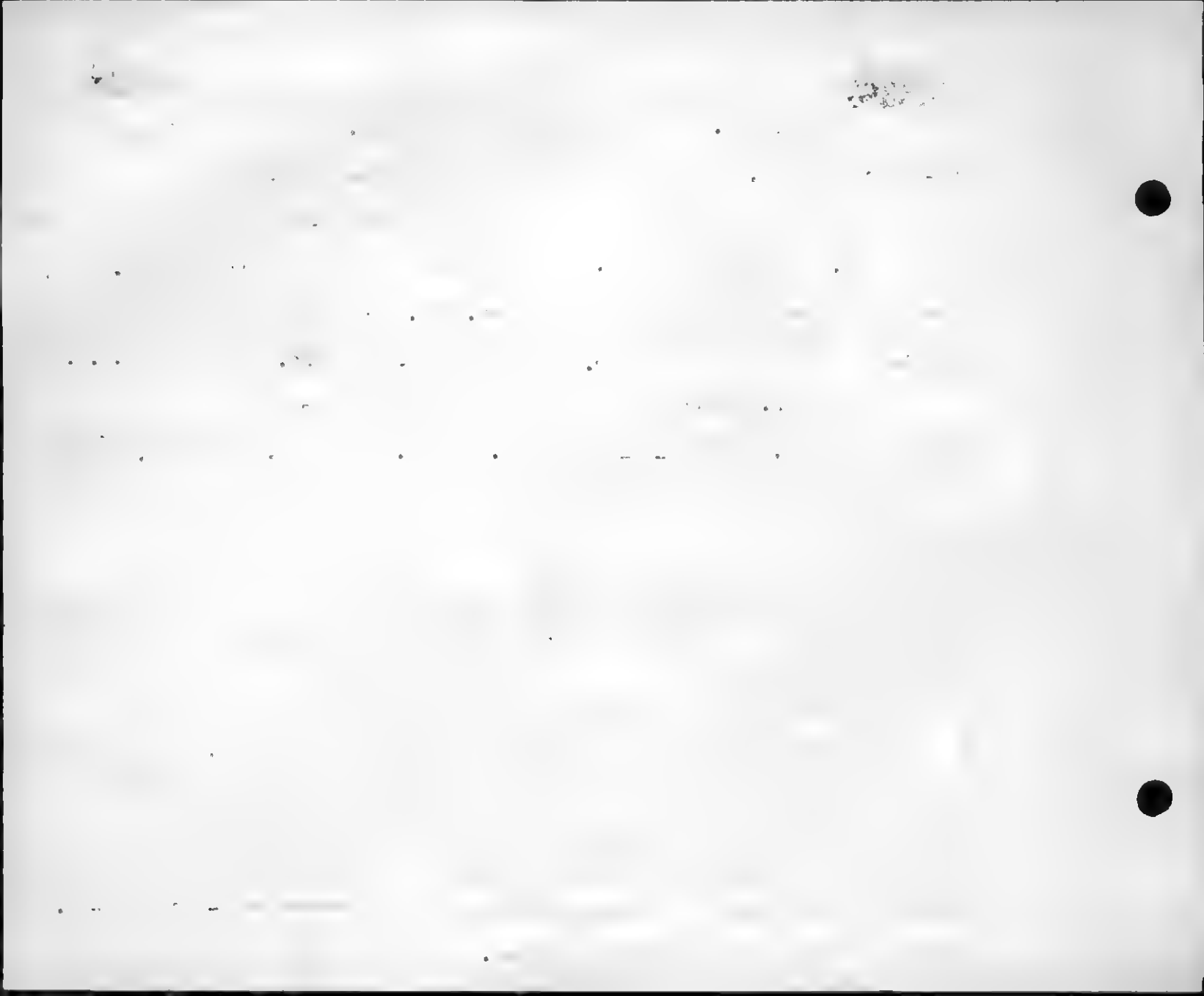
CERTIFICATE OF DEATH

04337

1. PLACE OF DEATH a. COUNTY <b>Washington Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Hagerstown Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chambersburg 17201</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>236 Lincoln Way East</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dr. Lewis</b> Middle <b>H.</b> Last <b>Seaton</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21st.</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 30th. 1885</b>
9. AGE (In years last birthday) yrs <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dr.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Uniontown Penna.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Lewis M. Seaton</b>		14. MOTHER'S MAIDEN NAME <b>Julia Stacy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1st W. War</b>		16. SOCIAL SECURITY NO. <b>179-36-3418</b>	
17. INFORMANT <b>Dr. Lewis H. Seaton</b>		<b>17500 McDade Court 2nd. Derwood Md. -20855</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis - Generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 yrs.</b> <b>2 yrs. +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Vess. Arteriosclerotic Disease - senility</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 2, 1966</b> , to <b>Mar. 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 21, 1967</b> , and that death occurred at <b>5:30 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Lloyd A. Heffman</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Heffman</b>		22d. ADDRESS <b>214 N. Pot-st. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/23/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Chambersburg - Franklin-Pa.</b>
24. FUNERAL DIRECTOR <b>Sellers Funeral Home Chambersburg Penna.</b>		25a. REC'D BY REGISTRAR <b>MAR 23 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04336

04338

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R#6</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Salem Church Road</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL CALVIN SECRIST</u>		4 DATE OF DEATH Month Day Year <u>March 8 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 28 1880</u>
9 AGE (in years last birthday) <u>86</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Sylvan Franklin Co Pa.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Abraham Secrist</u>		14 MOTHER'S MAIDEN NAME <u>Susan Zimmerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>David P. Secrist</u>		Address <u>Hagerstown Md R #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4-31 DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>not known</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Gastro-Intestinal Bleeding - Cause, not known</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>3-7, 1967</u> to <u>3-8, 1967</u> that (I) (we) last saw the deceased alive on <u>3-7, 1967</u> and that death occurred at <u>7:45 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Riego</u> M.D.		22b. DATE SIGNED <u>3/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR RIEGO</u>		22d. ADDRESS <u>154 W. Washington St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lutheren Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Sylvan Franklin Co Pa</u>	
24 FUNERAL DIRECTOR <u>Hagerstown Md.</u> <u>Andrew K. Coffman</u>		25a. RECEIVED BY REGISTRAR <u>March 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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45017



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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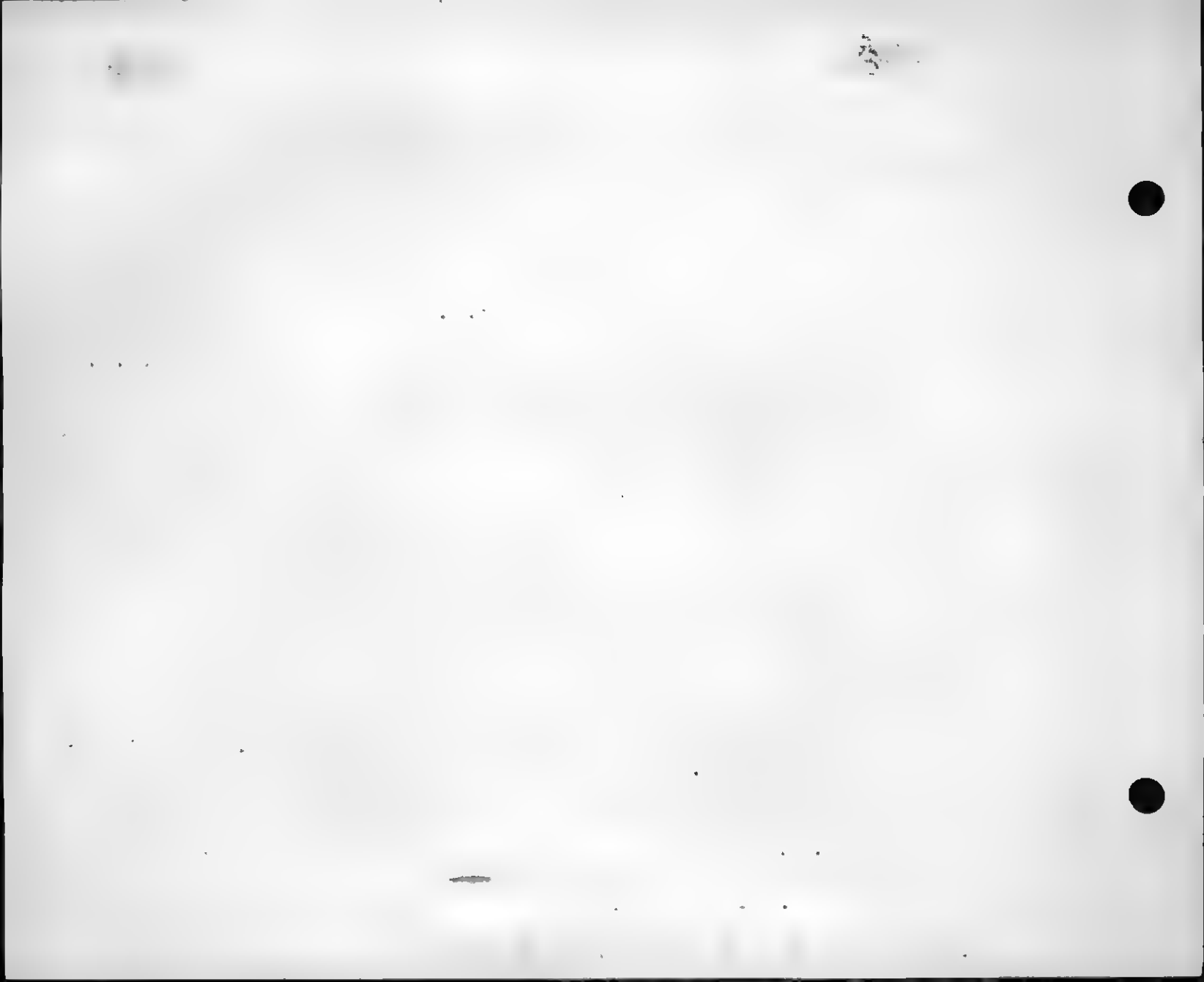
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04337

CERTIFICATE OF DEATH

04339

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILLIAMSPORT</b>			c. LENGTH OF STAY IN 1b <b>45 YRS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILLIAMSPORT</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOME</b>				d. STREET ADDRESS <b>23 W. CHURCH ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>HORINE</b> Last <b>SHANK</b>				4. DATE OF DEATH Month <b>3</b> Day <b>28</b> Year <b>19 67</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.2.1895</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERINTENDANT TEXTILE MILLS</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>FREDERICK COUNTY MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE SHANK</b>				14. MOTHER'S MAIDEN NAME <b>ESTA HORINE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>ANNIE A SHANK 23 W. CHURCH WILLIAMSPORT MD. T</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>No</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day 10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Williamsport Maryland</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 25 19 60</b> , to <b>Feb. 9</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9</b> , 19 <b>67</b> , and that death occurred at <b>3:38</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>M. E. Byrkit</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit</b>				22d. ADDRESS <b>28 West Potomac Street, Williamsport</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3.31.67</b>		23c. NAME OF CEMETERY OR CREMATOR <b>ST. PAUL</b>		23d. LOCATION (City or Town) (County) (State) <b>RURAL CLEARSPRING WASH. MD</b>	
24. FUNERAL DIRECTOR <b>Howard F. Howe Williamsport md</b>				25a. REC'D BY REGISTRAR <b>APR 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James J. J...</b>	



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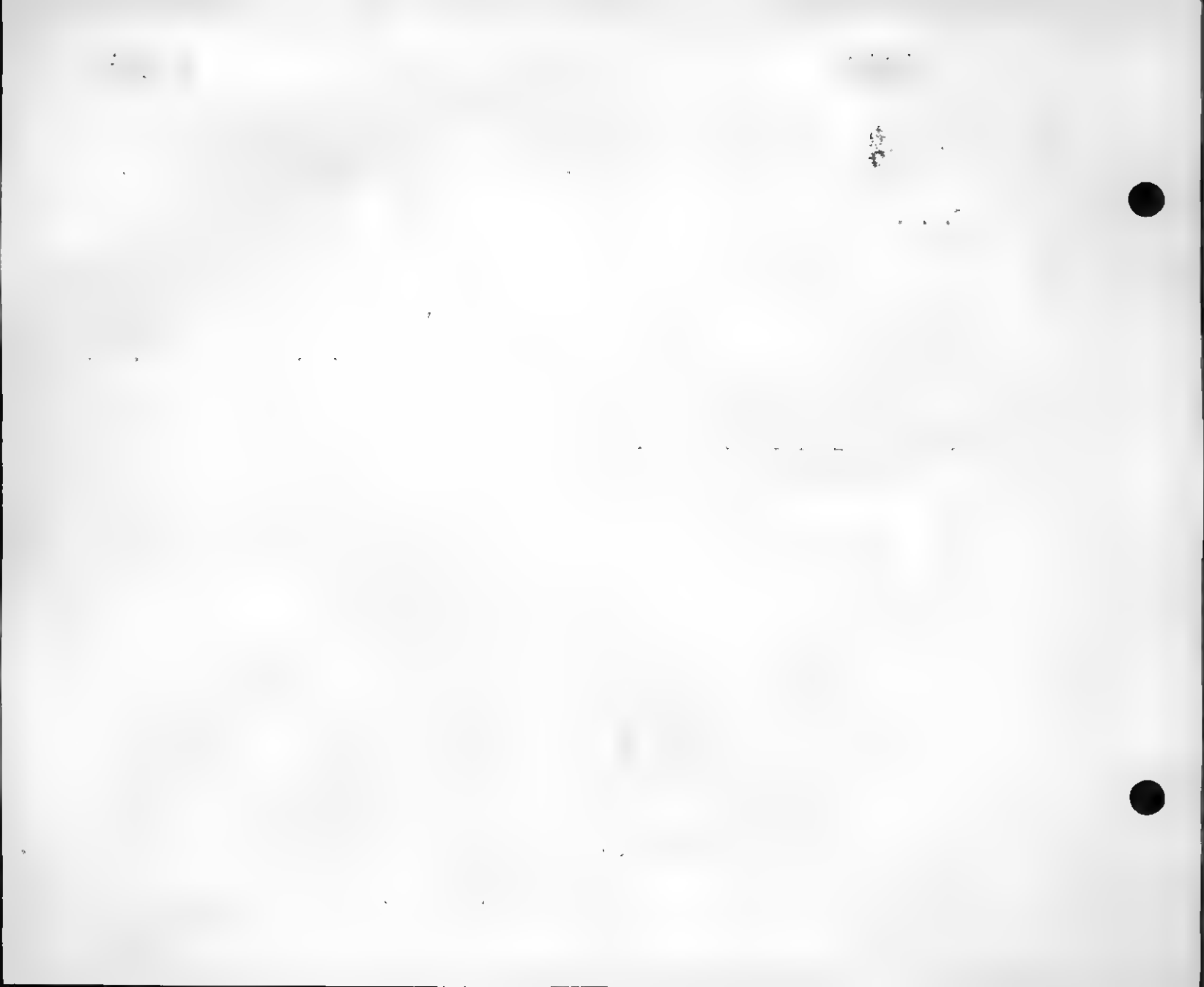
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04338

CERTIFICATE OF DEATH

04340

1 PLACE OF DEATH a COUNTY <b>WASHINGTON</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b COUNTY <b>WASHINGTON</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c LENGTH OF STAY IN 1b <b>3 MOS.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. WASHINGTON COUNTY HOSPITAL</b>		e STREET ADDRESS <b>LEITERSBURG PIKE</b>	
3 NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>BERLEY</b> Last <b>SHEALY</b>		4 DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MAY 20, 1900</b>
9 AGE (In years last birthday) <b>66</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SCHOOL TEACHER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>NEWBERRY CO., S. CAROLINA</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>NOAH E. SHEALY</b>		14 MOTHER'S MAIDEN NAME <b>JANE CHAPMAN</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>456-03-5034</b>	
17 INFORMANT <b>MRS. KATHERINE SHEALY</b>		<b>HAGERSTOWN, MARYLAND</b> <b>LEITERSBURG PIKE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Acute Coronary Occlusion</b> (c) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>Unkn</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>March 3, 1967</b> to <b>March 7, 1967</b> that (I) (we) last saw the deceased alive on <b>March 7, 1967</b> , and that death occurred at <b>12:20 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Lawrence L. Packer, Jr.</b>		22b DATE SIGNED <b>3/7/1967</b>	
22c PHYSICIAN'S NAME (Type) <b>LAWRENCE L. PACKER, JR. M.D.</b>		22d ADDRESS <b>145 W. WASHINGTON ST. HAGERSTOWN, MD.</b>	
23a B. JRIA, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>3/7/1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>GRAND VIEW MEM. PARK CEM.</b>	23d LOCATION (City or Town) (County) (State) <b>ROCK HILL S. CAROLINA</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		25a REC'D BY REGISTRAR <b>MAR 10 1967</b>	
ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

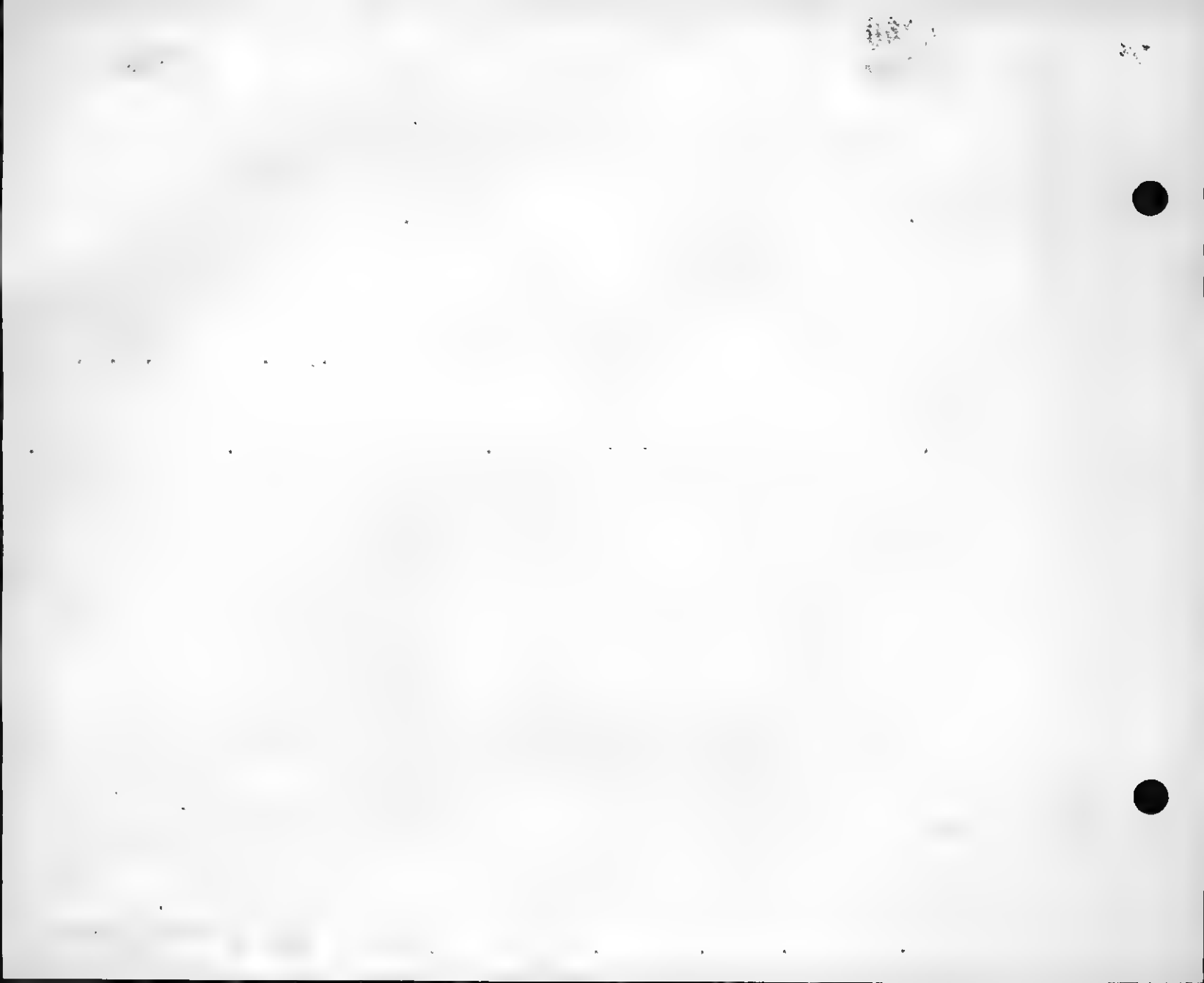
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04339

CERTIFICATE OF DEATH

04341

1 PLACE OF DEATH a. COUNTY Washington MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keedysville		c. LENGTH OF STAY IN 1b 26 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keedysville 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rfd. 1			d. STREET ADDRESS Rfd. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Blanche Estelle Shelby			4 DATE OF DEATH Month Day Year March 5, 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 14, 1900	9 AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min. 11 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME George Haller		
14. MOTHER'S MAIDEN NAME Lola Younkings			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		
16. SOCIAL SECURITY NO 216-48-6566		17. INFORMANT Address Mrs. Virginia Hutzell, Rfd. 2, Boonsboro, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio Vascular Disease</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (d) _____					INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>March 1</i> , 19 <i>67</i> to <i>March 5</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 4</i> , 19 <i>67</i> , and that death occurred at <i>11 P.</i> M, from causes and on the date stated above.					
22a. SIGNATURE <i>G. W. LeVan</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>March 7, 1967</i>		
22c. PHYSICIAN'S NAME (Type) <i>G. W. LeVan</i>		22d. ADDRESS <i>Boonsboro Washington</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF <i>3-8-67</i>	23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City or Town) (County) (State) <i>Middletown, Md.</i>	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR <i>MAR 9 1967</i>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Juge</i>



04447

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04340

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>4 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Coffman Home for Aging</u>				d. STREET ADDRESS <u>Springfield State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELSIE</u> Middle <u>MAY</u> Last <u>SHIPP</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 6 1895</u>	
9. AGE (In years past birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cyrus J. Shipp</u>				14. MOTHER'S MAIDEN NAME <u>Mary Blair</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>215-14-1904</u>		17. INFORMANT <u>Mrs Marie Heyworth</u> Address <u>66 West Side Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Atherosclerotic heart disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Mar. 18</u> , 19 <u>67</u> to <u>Mar. 18</u> , 19 <u>67</u> , that (I) <u>(we)</u> saw the deceased alive on <u>attendance</u> <u>11:55</u> M, and that death occurred at <u>11:55</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William T. Layman, M.D.</u>				22b. DATE SIGNED <u>Mar 21, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
23d. LOCATION (City or Town) <u>Hagerstown W<sup>h</sup> Co Md</u>				23e. REC'D BY REGISTRAR <u>MAR 22 1967</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04341 CERTIFICATE OF DEATH 04342

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RFD 1, Clear Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>RFD 1, Clear Spring</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Allen Shirley</u>				4. DATE OF DEATH Month Day Year <u>March 5th, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 13, 67</u>	
9. AGE (In years last birthday) yrs. <u>21</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) Months Days Hours Min. <u>21</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edwin T. Shirley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Hull</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edwin T. Shirley</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart disease</u> DUE TO (b) <u>Branchopneumonia</u> DUE TO (c) <u>Meningo-myelocytic Clubhands &amp; feet</u>				INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>20 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/13/1967</u> to <u>3/5/1967</u> , that (I) (we) last saw the deceased alive on <u>3/4/1967</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. M. Bacon</u>				22b. DATE SIGNED <u>3/6/67</u>		22c. PHYSICIAN'S NAME (Type) <u>G. M. Bacon</u>	
22d. ADDRESS <u>Clear Spring,</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 7, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Park Road</u>		23d. LOCATION (City, town or county) (State) <u>Wash. Co. Maryland</u>	
24. FUNERAL DIRECTOR <u>Donald E. Thompson</u>				25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

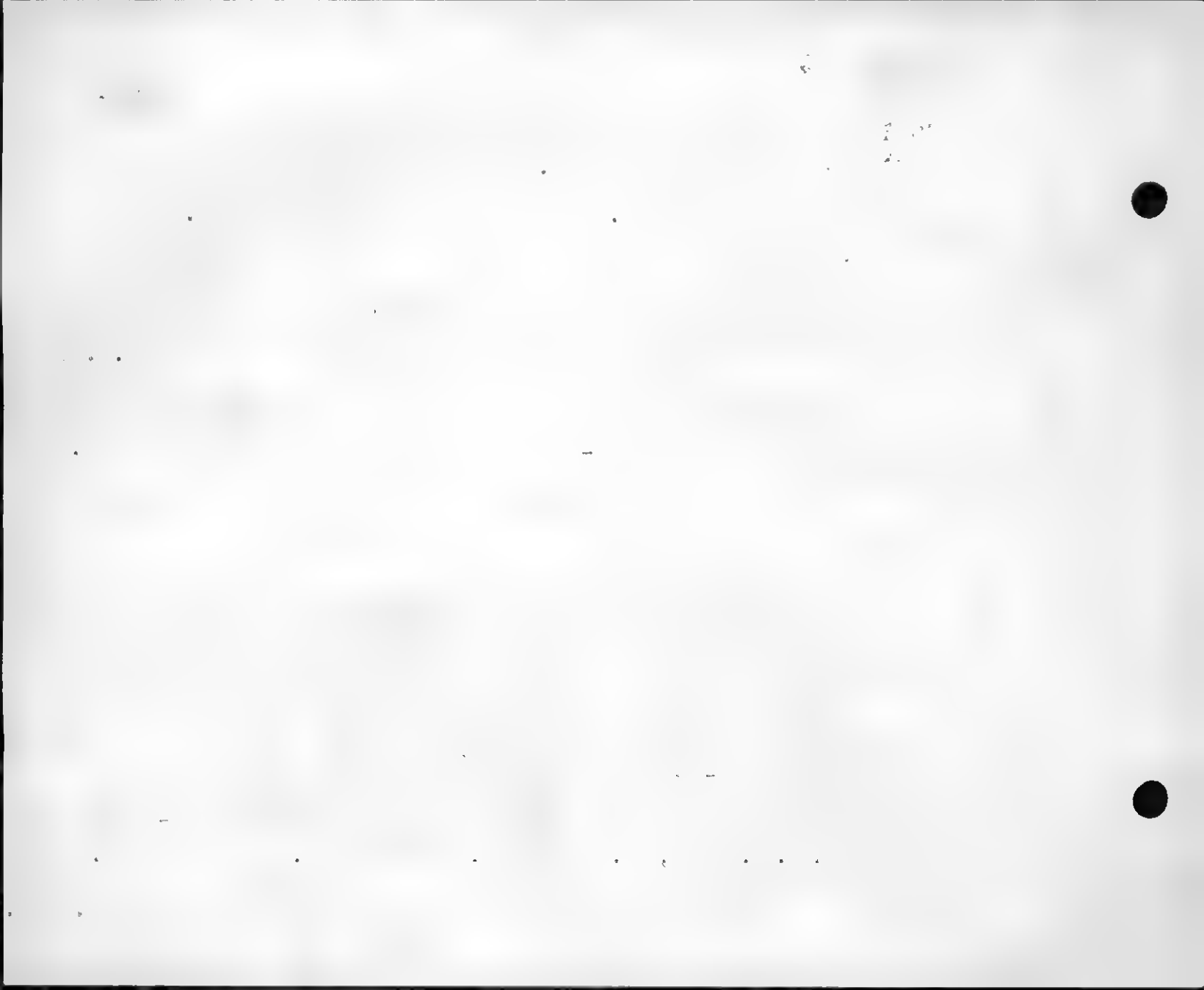
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04342		04343	
1 PLACE OF DEATH a COUNTY <b>WASHINGTON</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>WASHINGTON</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILLIAMSPORT</b>		c LENGTH OF STAY IN b <b>3 YRS.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOMEWOOD CHURCH HOME, INC.</b>		e STREET ADDRESS <b>309 S. MULBERRY ST.</b>	
3. NAME OF DECEASED (Type or print) <b>ANNA MAY SIGLER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>21</b> Year <b>19 67</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>10/28/1870</b>
9. AGE (In years last birthday) <b>96</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISAAC REYNOLDS</b>		14. MOTHER'S MAIDEN NAME <b>ANN REBECCA FULTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>220-52-2109J1</b>	
17. INFORMANT <b>MR. VERNON R. SNIDER</b>		Address <b>HAGERSTOWN MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> DUE TO (b) <b>Senility</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS A T.O.P.S.Y. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>1-2-</b> , 19 <b>61</b> , to <b>3-21-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2-27-</b> , 19 <b>67</b> , and that death occurred at <b>7:30</b> M., from causes and on the date stated above.			
22a SIGNATURE <i>Dr. E. W. Ditto, Jr.</i>		22b DATE SIGNED <b>3-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22d. ADDRESS <b>215 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b DATE THEREOF <b>3/23/67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>CAVETOWN REFORMED CHURCH</b>		23d LOCATION (City or Town) (County) (State) <b>CAVETOWN WASH. MD.</b>	
24 FUNERAL DIRECTOR <i>W. J. Harwood, Hagerstown, Md.</i>		25a REC'D BY REGISTRAR <b>MAR 27 1967</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

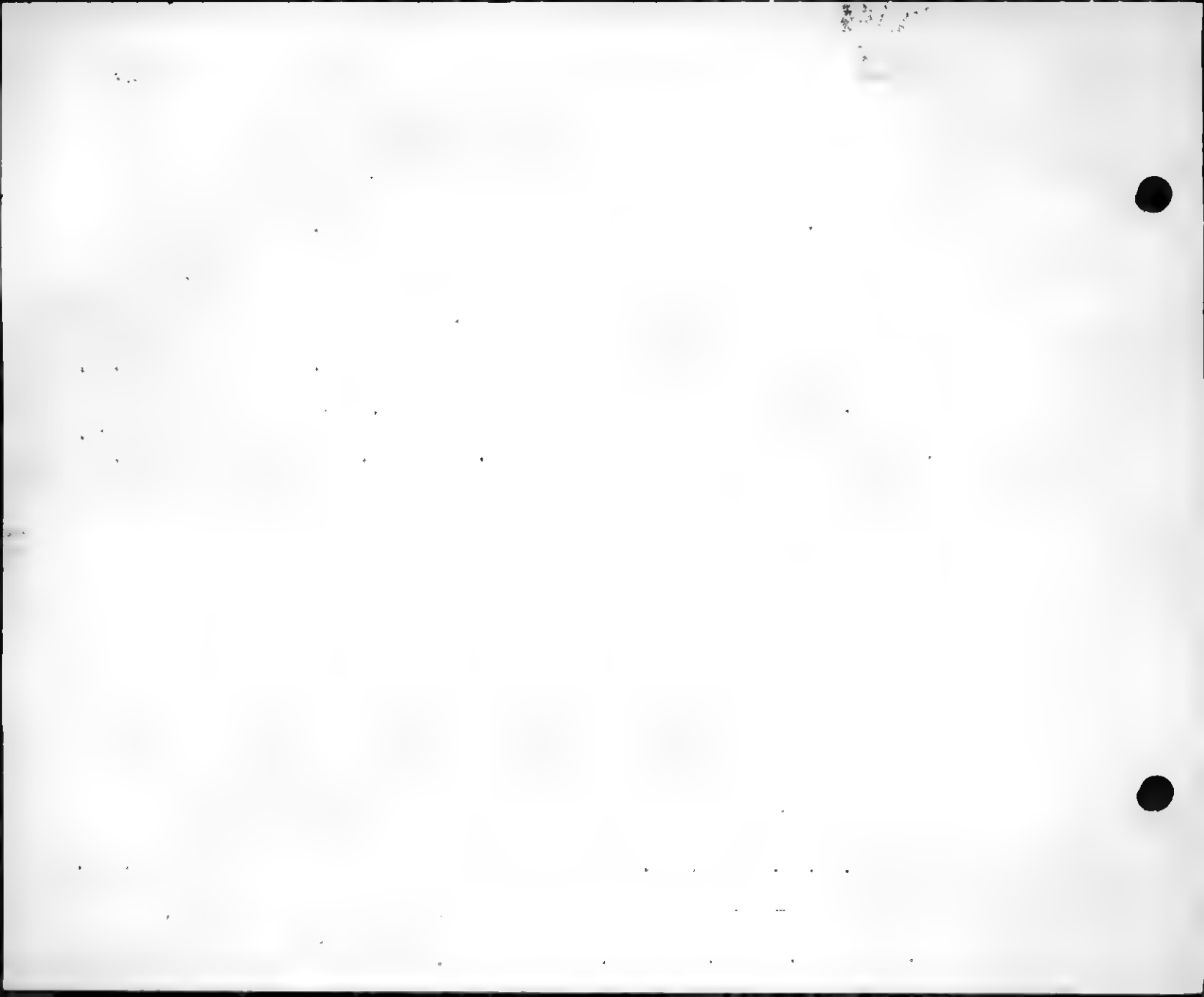
VR A15ME (5)  
6M 1/66

04343

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04344

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b> c. LENGTH OF STAY N b <b>Life</b>			2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>15 Young Ave.</b>			d. STREET ADDRESS <b>15 Young Ave.</b>		
3 NAME OF DECEASED (Type or print) <b>Guy Wilbur Smith</b>			4 DATE OF DEATH <b>March 17, 19 67</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 22, 1900</b>		9 AGE (In years last birthday) <b>66</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11 BIRTHPLACE (State or foreign country) <b>Boonsboro, Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13 FATHER'S NAME <b>Donivan C. Smith</b>		
14. MOTHER'S MAIDEN NAME <b>Martha E. Lapole</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		
16 SOCIAL SECURITY NO <b>220-05-6807</b>			17 INFORMANT <b>Mrs. Myrtle E. Smith, 15 Young Ave.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b> EXAMINER'S NAME (Type)			22. DATE SIGNED <b>3-18-67</b> Address (Street, city, town, or county) <b>Hagerstown, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-20-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>		
24 FUNERAL DIRECTOR <b>John H. East, Jr. 112 N. Main St. Boonsboro, Md.</b>			25a. REC'D BY REGISTRAR <b>MAR 21 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04344

CERTIFICATE OF DEATH

04345

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewsville P.O. Box 92</u>		c. LENGTH OF STAY IN TB <u>11 Yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chewsville Box # 92</u>		d. STREET ADDRESS <u>Waltz Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Waltz Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VICTOR</u> Middle <u>(NMN)</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10 1894</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pa. Carnegie Alleganey Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Keuster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>567-01-2796</u>	
17. INFORMANT <u>Mrs Corena Smith Chewsville Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases, abdominal &amp; generalized</u> 1527 DUE TO (b) <u>Sarcoma, primary in jejunum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 months</u> <u>certain</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(the deceased)</u> attended the deceased from <u>Feb. 28</u> , 1967, to <u>Mar. 8</u> , 1967, that (I) <u>(was)</u> last saw the deceased alive on <u>Mar. 8</u> , 1967, and that death occurred at <u>6:15 P.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William T. Layman, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		22d. ADDRESS <u>100 Professional Arts Bldg, Hag., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the deceased, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





CERTIFICATE OF DEATH

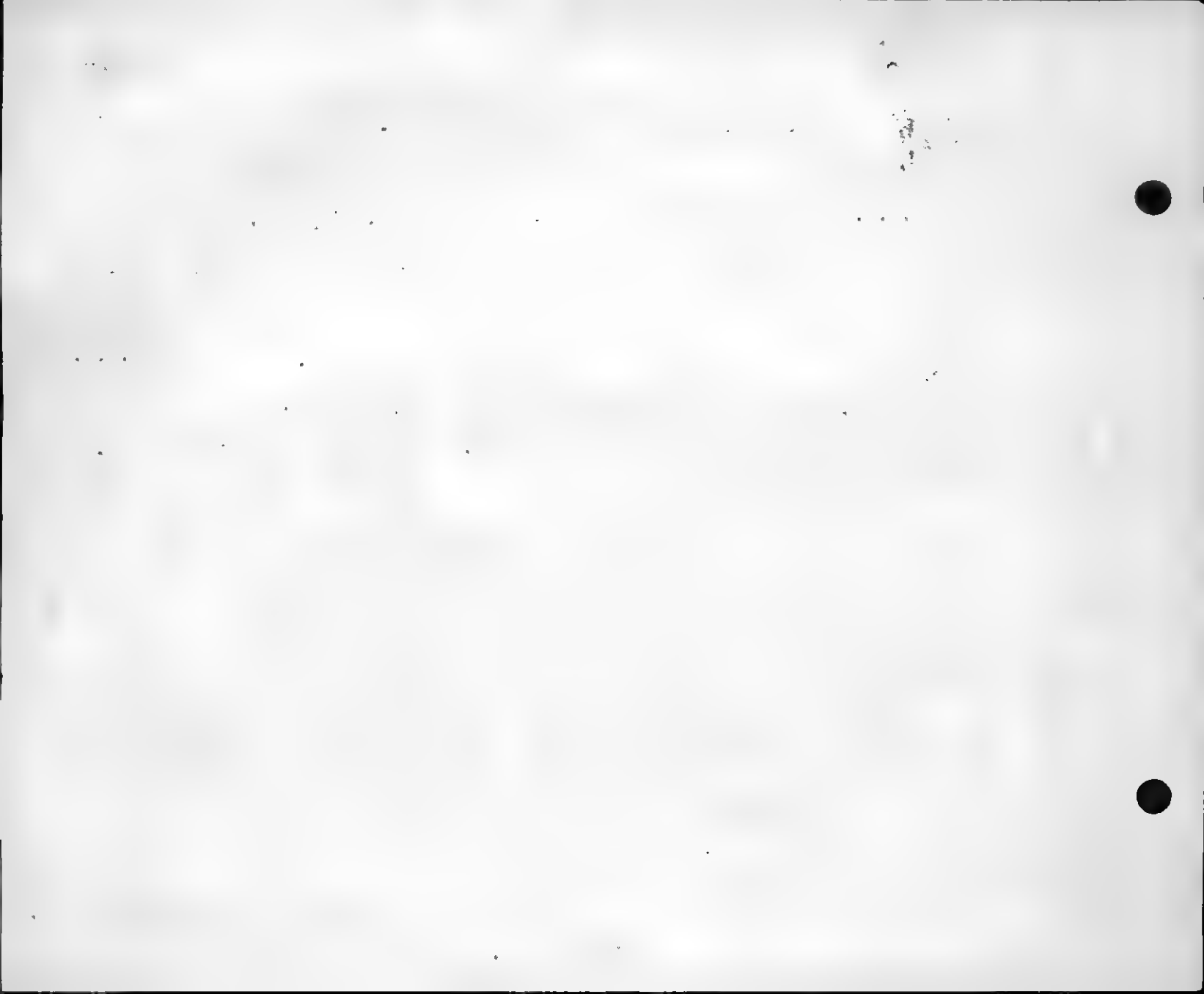
04345

04346

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Washington County Hospital</b>		d. STREET ADDRESS <b>22 Mt. Airy Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Hypatia</b> Middle <b>Ann</b> Last <b>Snider</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/6/1896</b>
9. AGE (In years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Waynesboro Pa.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles D. Snider</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Stewart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Paul McFerren, Waynesboro Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO (b) <b>Cardiac Hypertrophy</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1967</b> to <b>March 1967</b> that (I) (we) last saw the deceased alive on <b>March 4, 1967</b> , and that death occurred at <b>2:40 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Edson B. Moody</b>		22b. DATE SIGNED <b>3/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edson B. Moody</b>		22d. ADDRESS <b>145 S. PROSPECT ST. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/9/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Price</b>	23d. LOCATION (City or Town) (County) (State) <b>Waynesboro #2, Franklin Pa.</b>
24. FUNERAL DIRECTOR <b>Walter J. Grove</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Waynesboro Pa.</b>		DATE <b>MAR 8 1967</b>	

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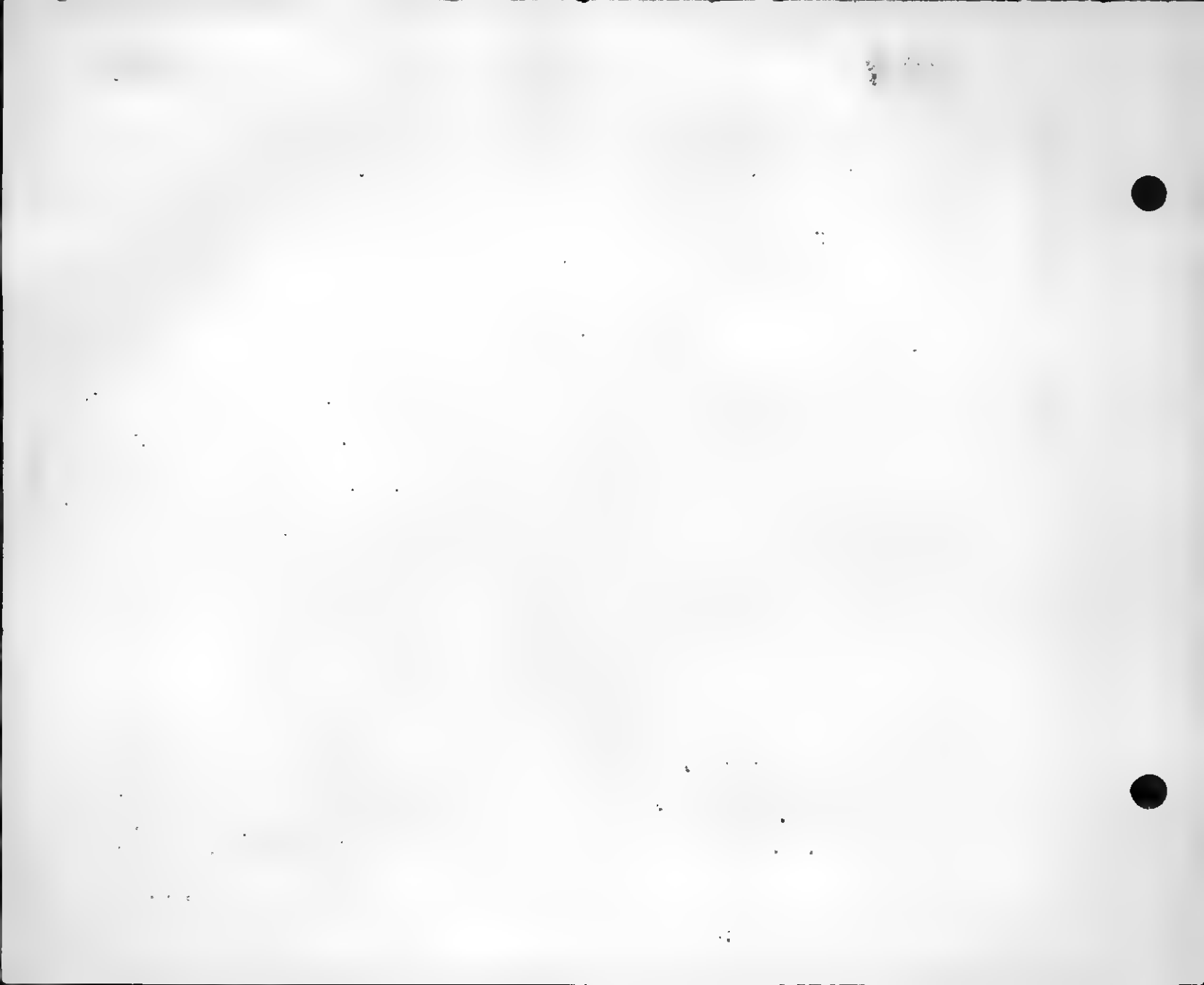


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

04346		04347	
1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>V</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Route #1 Sharpsburg</u>	
c. LENGTH OF STAY IN 1b <u>146 days</u>		d. STREET ADDRESS <u>211</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Robert Snyder</u>		4. DATE OF DEATH Month Day Year <u>MARCH 24 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1879</u>
9. AGE (in years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Park</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Scrapple West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Elizabeth Minnich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 20 8456 A</u>	
17. INFORMANT <u>Mrs. Mary Hensell</u>		Address <u>Rt #1 Sharpsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 221X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>March 22</u> , 19 <u>67</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Byrkit</u>		22b. DATE SIGNED <u>3-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. BYRKIT</u>		22d. ADDRESS <u>28 West Potomac Street Williamsport, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Reform Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Shepherdstown, W. Va.</u>	
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1

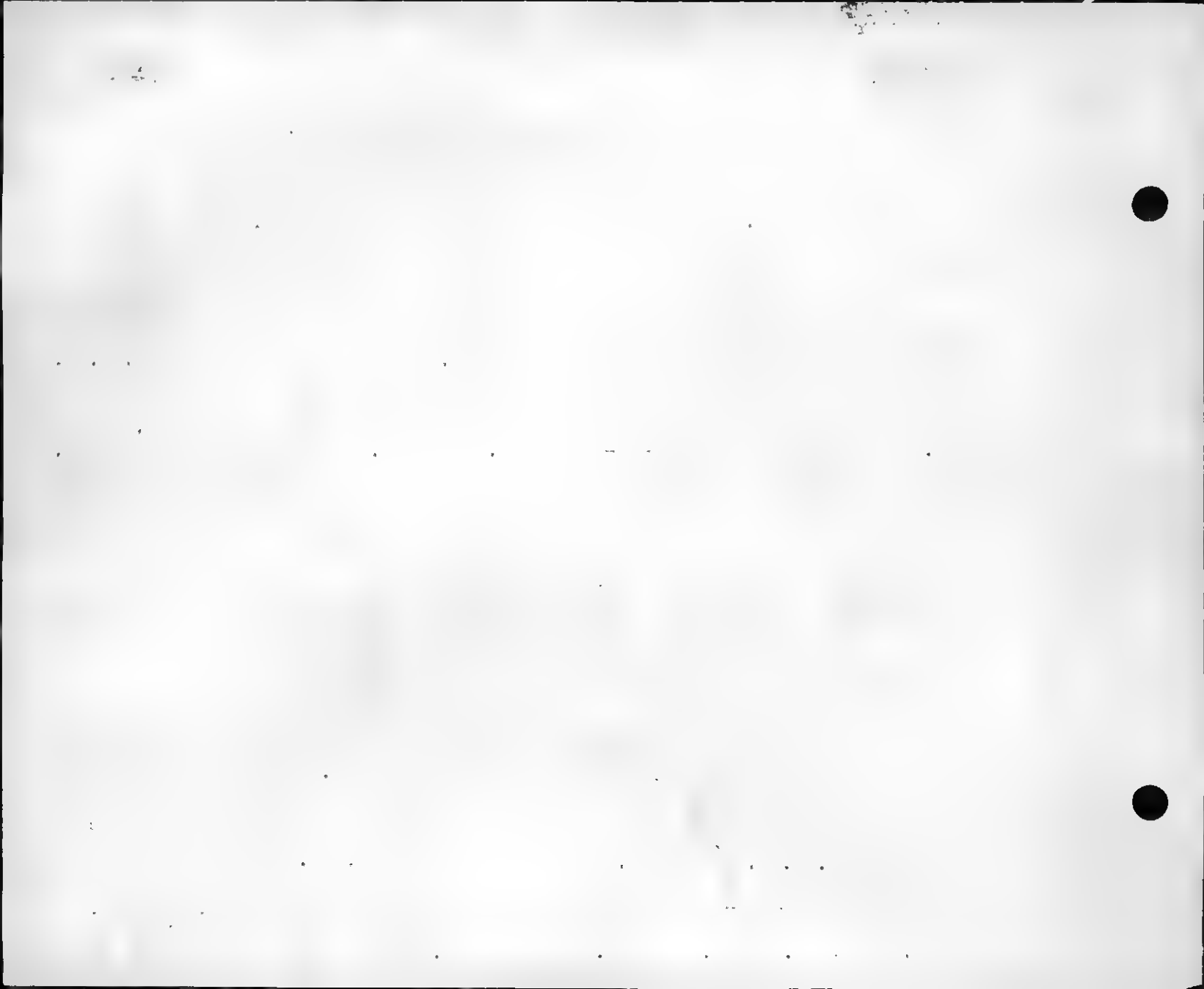
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04347

CERTIFICATE OF DEATH

04348

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>50 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11509 Virginia Ave.</u>		d. STREET ADDRESS <u>1509 Virginia Ave.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Jacob Alvey Snyder</u>		4 DATE OF DEATH Month Day Year <u>March 15, 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1883</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days <u>7 5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Mt. Carmel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Milton Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Ella Hildebrand</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>220-16-0812</u>	
17 INFORMANT <u>Hagerstown, Md.</u>		Mrs. Goldie D. Snyder, 1509 Virginia Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Leukemia Lymphatic Chronic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several days</u> <u>5 years</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1963</u> , to <u>March 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 13, 1967</u> , and that death occurred at <u>5 A. M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>March 17, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		22d. ADDRESS <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem Reformed Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rural Hagerstown, Md.</u>
24 FUNERAL DIRECTOR <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

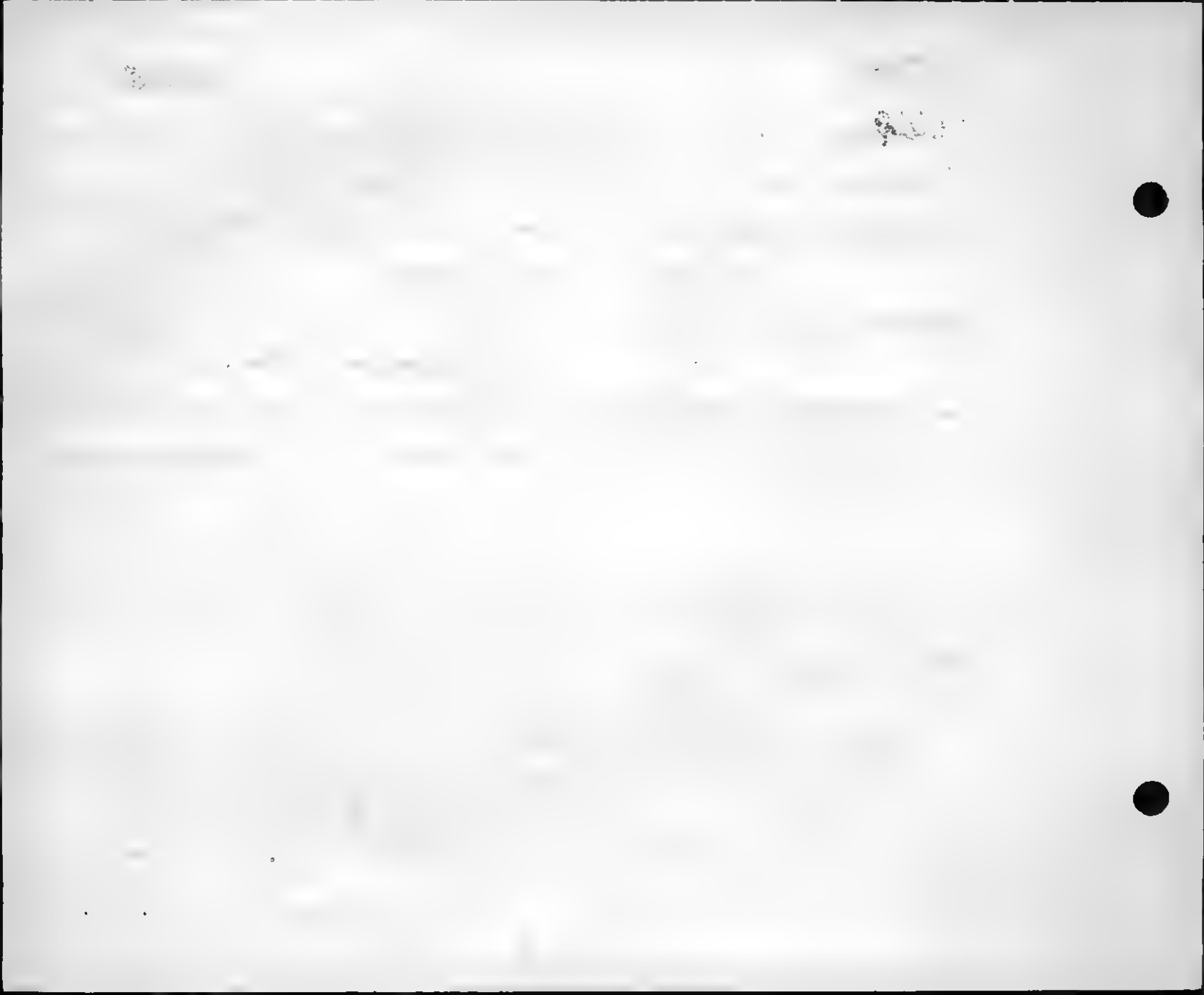
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04348

CERTIFICATE OF DEATH

04349

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>211</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>43 MEALEY PARKWAY</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>STEWART</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON Co. MARYLAND</u>
13. FATHER'S NAME <u>LAURENCE EVERETT STEWART</u>		14. MOTHER'S MAIDEN NAME <u>PATRICIA ALICE MACARTHUR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>MOTHER</u> Address <u>43 MEALEY PKWY.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>1645</u> <u>Cholelithiasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>immaturity</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>67</u> , to <u>3/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> 19 <u>67</u> , and that death occurred at <u>4:10</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>F. D. Dove Jr.</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. D. DOVE, JR., M.D.</u>		22d. ADDRESS <u>214 N. POTOMAC ST., HAGERSTOWN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>APRIL 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON COUNTY HOSPITAL</u>	23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN WASH. MD.</u>
24. FUNERAL DIRECTOR <u>John Schaffer, adm. Wash. Co. Hosp</u>		25. RECEIVED BY REGISTRAR DATE <u>APR 6 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04349

CERTIFICATE OF DEATH

04350

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE b. COUNTY Maryland Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb D.O.A. Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 144 So Mulberry St	
3 NAME OF DECEASED (Type or print) CLARENCE WILLIAM STOUFFER		4. DATE OF DEATH March 8 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16 1883
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt of Mails U.S. Post Office		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Downsville Wash Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. Cornelius Stouffer		14. MOTHER'S MAIDEN NAME Emma C. Hull	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-28-6873	
17. INFORMANT John R. Stouffer Sr		Address Hagerstown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X Carcinoma larynx DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/2, 1963, to 3/8, 1967, that (I) (we) last saw the deceased alive on 3/3/67 19, and that death occurred at 6:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert V. Campbell M.D.		22b. DATE SIGNED 3/10/67	
22c. PHYSICIAN'S NAME (Type) Robert V. Campbell		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/12/67	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	23d. LOCATION (City or town) (County) (State) Bakersville Wash Co Md
24. FUNERAL DIRECTOR Andrew K. Coffman		25a. REC'D BY REGISTRAR MAR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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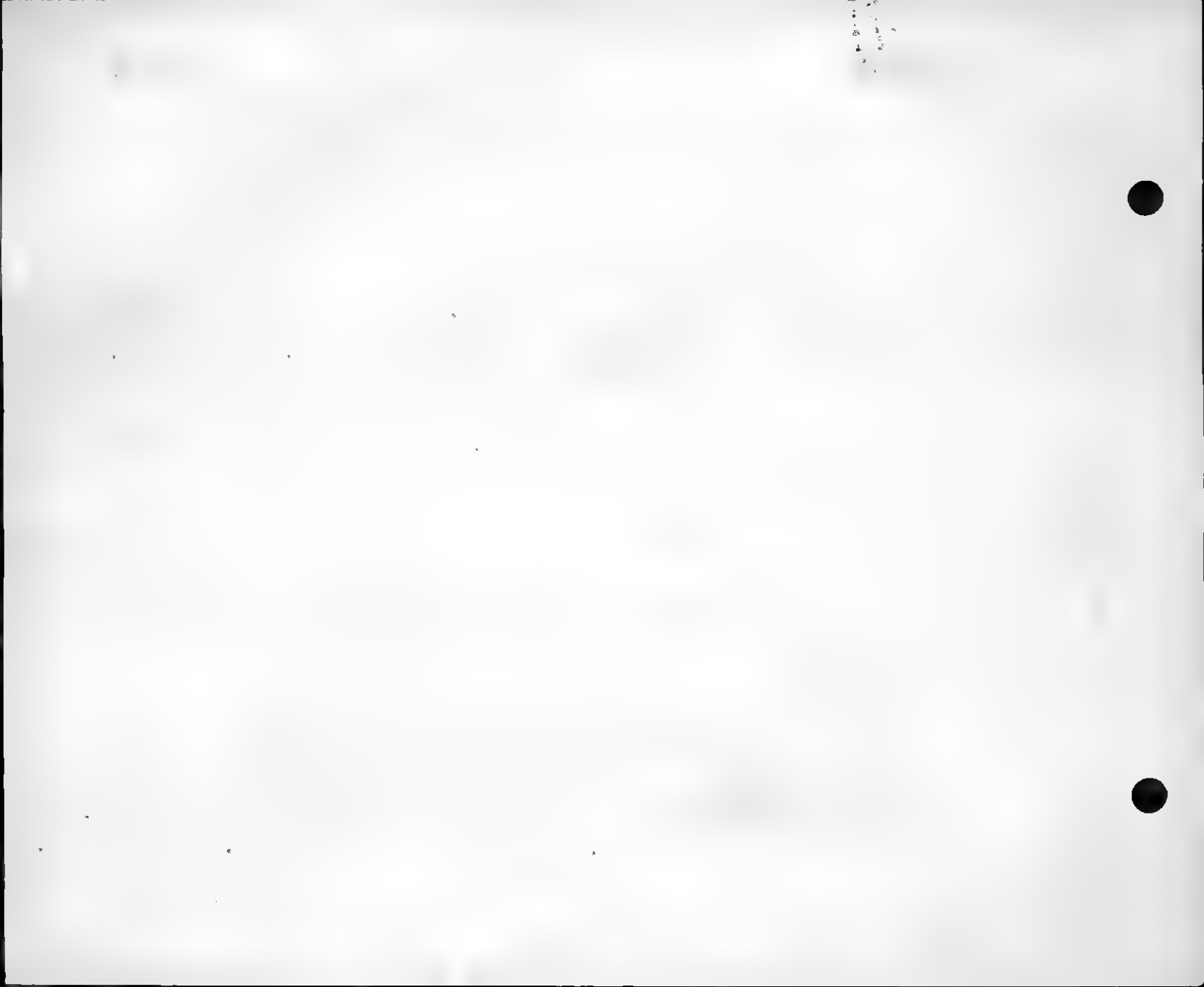
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04350

CERTIFICATE OF DEATH

04351

1 PLACE OF DEATH o COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c LENGTH OF STAY IN TB 47 YRS.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARTIN MANOR CONV. HOME		d. STREET ADDRESS 1004 MULBERRY AVENUE	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last CLARENCE GASKILL TOMLINSON		4. DATE OF DEATH Month Day Year MARCH 9 19 67	
5. SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 2, 1897
9 AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11 BIRTHPLACE (County & State, or foreign country) PHILADELPHIA CO., PENNA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME ALBERT S. TOMLINSON		14 MOTHER'S MAIDEN NAME MARY NEALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 705-10-4622	
17 INFORMANT HAGERSTOWN, MARYLAND		MRS. LOUISE TOMLINSON 1004 MULBERRY AVE.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pylonephritis DUE TO (b) Proteus DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive and atherosclerotic heart disease. Malignant tumor of prostate--paraganglioma		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 19 65 to March 9 1967, that (I) (we) last saw the deceased alive on March 9 1967, and that death occurred at 7:50 PM, from causes and on the date stated above			
22a SIGNATURE W. T. Layman		22b. DATE SIGNED March 10, 1967	
22c. PHYSICIAN'S NAME (Type) WILLIAM T. LAYMAN M.D.		22d. ADDRESS PROFESSIONAL ARTS Bg. HAGERSTOWN, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF MARCH 13, 1967	
23c NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d LOCATION (City or Town) (County) (State) HAGERSTOWN, MARYLAND	
24. FUNERAL DIRECTOR CHARLES M. ROUZER HAGERSTOWN, MARYLAND		25a. REC'D BY REGISTRAR DATE MAR 15 1967	
25b. REGISTRAR'S SIGNATURE John J. Judge			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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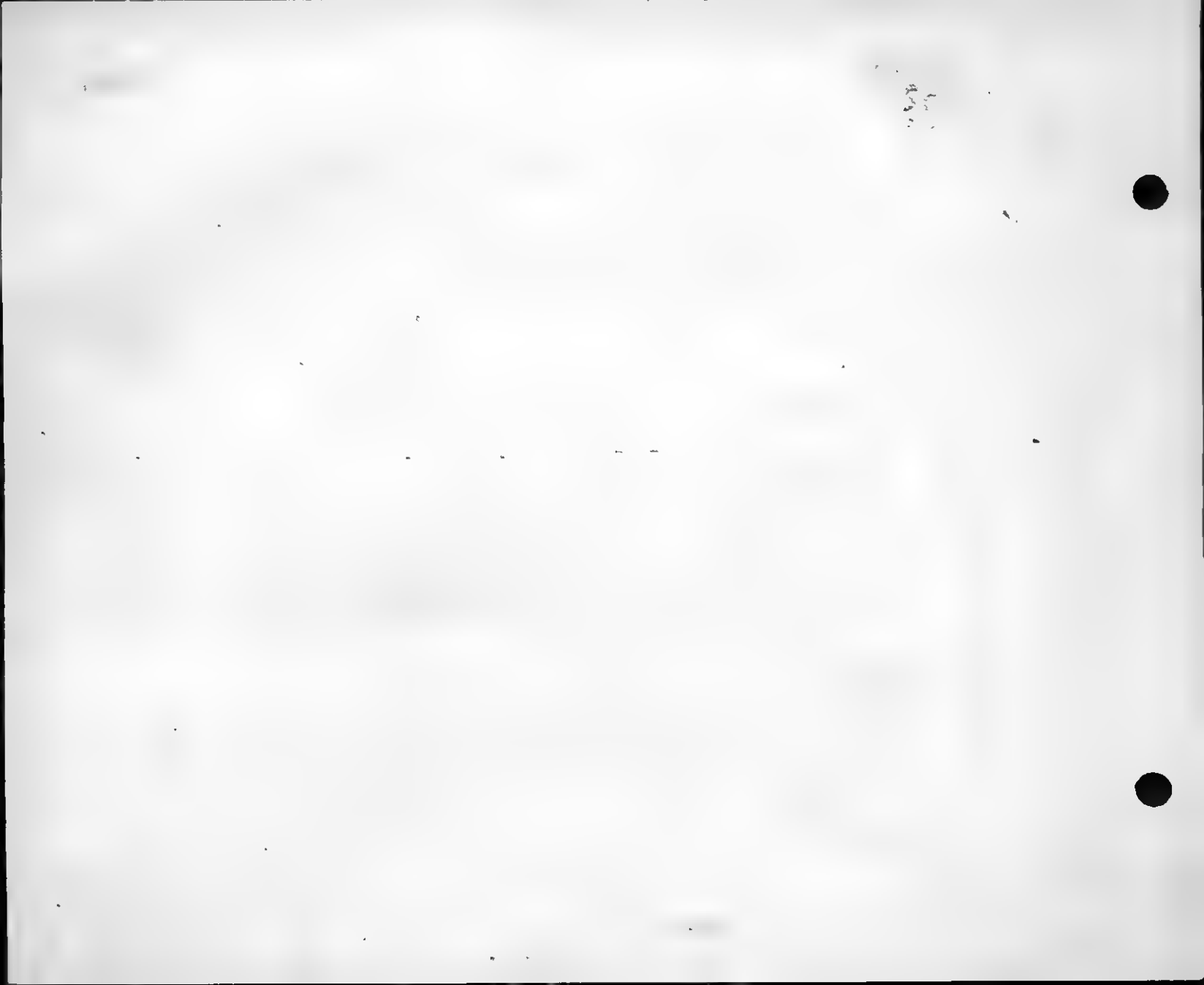
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04351

CERTIFICATE OF DEATH

04352

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonesboro</u>		c. LENGTH OF STAY IN Tb <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reeder Nursing Home</u>		e. STREET ADDRESS <u>231 Westside Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Alverta</u> Last <u>Troup</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1880</u>
9. AGE (In years last birthday) yrs. <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hanover, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Ernst</u>		14. MOTHER'S MAIDEN NAME <u>Lidia Auchey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>175-10-5886</u>	
17. INFORMANT <u>Mr. Clair H. Troup 231 Westside Ave.</u>		Address: <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiac disease</u> DUE TO (b) <u>disease</u> DUE TO (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1967</u> , to <u>March 14, 1967</u> , that (I) (we) lost the deceased alive on <u>March 11, 1967</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>G. W. Ke Van</u>		22b. DATE SIGNED <u>3-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. Ke Van</u>		22d. ADDRESS <u>Boonesboro, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Hark</u>		25a. REC'D BY REGISTRAR <u>MAR 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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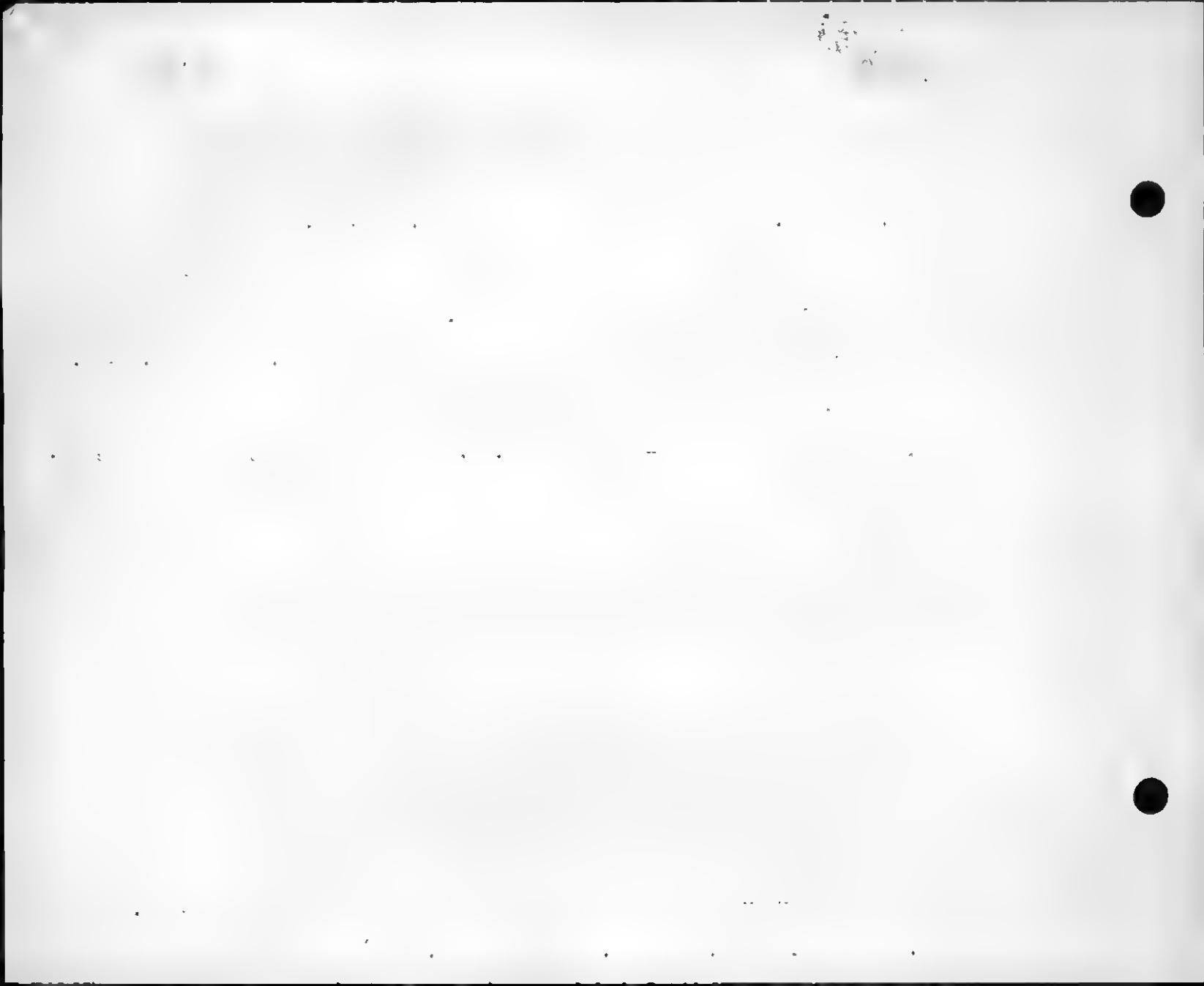
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b> c. LENGTH OF STAY in 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>54 N. Main St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b> d. STREET ADDRESS <b>54 N. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Ray Valentine</b> First Middle Last		4. DATE OF DEATH <b>March 3, 1967</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1905</b>
9. AGE (in years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min <b>2 19</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholster</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Keedysville, Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. FATHER'S NAME <b>William A. Valentine</b>		16. MOTHER'S MAIDEN NAME <b>Martha Emerson</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		18. SOCIAL SECURITY NO <b>214-09-6677</b>	
19. INFORMANT <b>Mr. C. Foster Valentine, Keedysville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>1201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-1-1965</b> to <b>3-3-1967</b> , that (I) (we) last saw the deceased alive on <b>3-3-1967</b> , and that death occurred at <b>8 P. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Secondari</b>		22b. DATE SIGNED <b>3-4-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>		22d. ADDRESS <b>Boonsboro Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Keedysville, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04353

CERTIFICATE OF DEATH

04354

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN TB <b>life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>324 Vista St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DORIS MARIE VULGAMOTT</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24, 1921</b>
9. AGE (In years last birthday) yrs <b>46</b>		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Dorrick F. Byrd</b>		14. MOTHER'S MAIDEN NAME <b>Agnes B. Ashby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Jack Osborne, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Lobar Pneumonia</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RUSSK FORTUNE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-23</b> , 19 <b>67</b> , to <b>3-27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3-27</b> , 19 <b>67</b> , and that death occurred at <b>10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>E. J. Lardizabal</b>		22b. DATE SIGNED <b>3-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. J. Lardizabal</b>		22d. ADDRESS <b>301 W. Preston Street, Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>3-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DA MAR 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

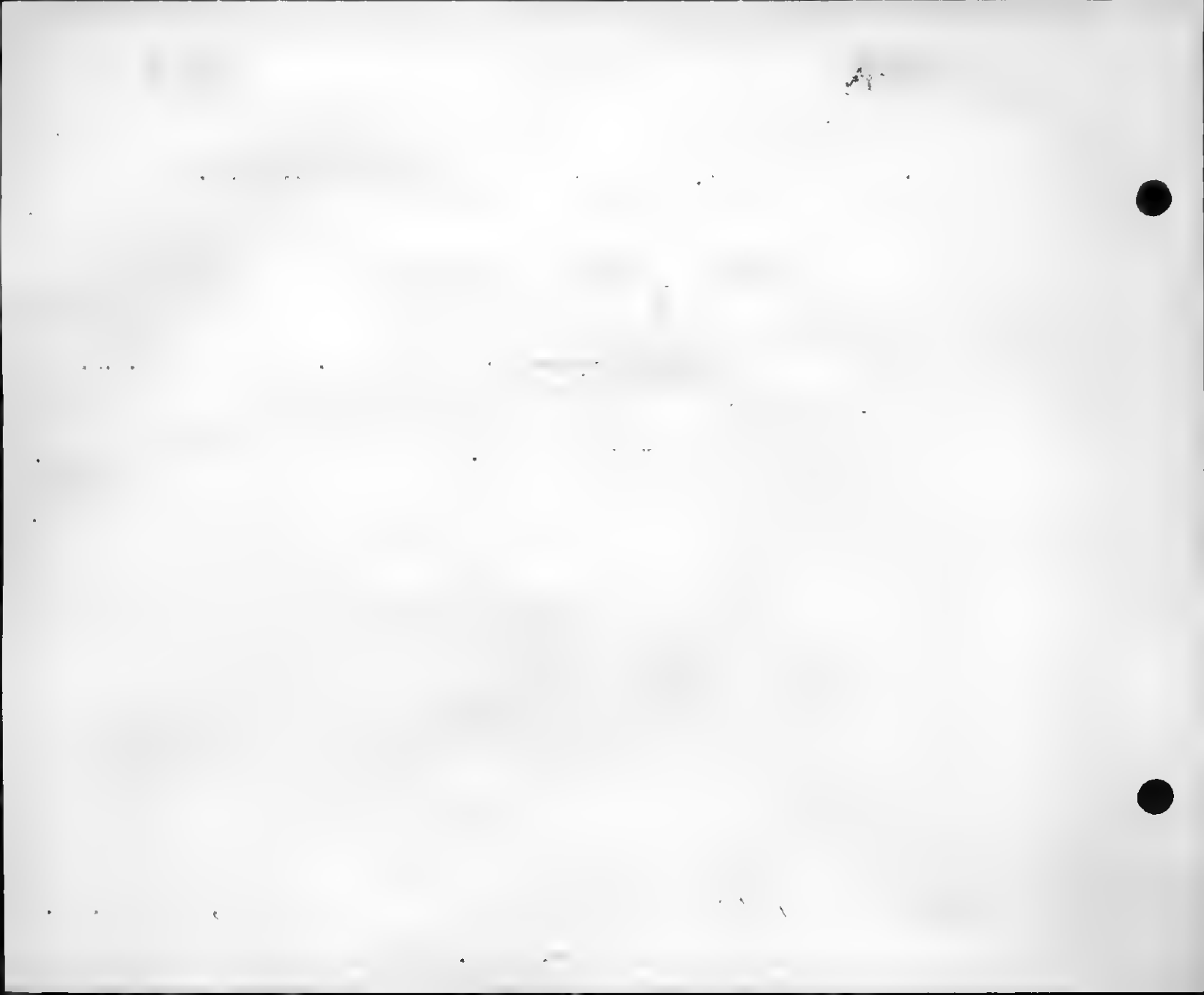
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04354

CERTIFICATE OF DEATH

04355

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pen Mar, Penna.</b>			c. LENGTH OF STAY IN 1b <b>47 yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pen Mar, Penna.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Dean</b> Last <b>Werdebaugh</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1967</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/23/1892</b>		9. AGE (In years last birthday) yrs <b>74</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Franklin, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harry S. Werdebaugh</b>				14. MOTHER'S MAIDEN NAME <b>Laura Greenwood</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>715-03-4676</b>		17. INFORMANT <b>Mrs. Thelma Werdebaugh</b>		Address <b>Box 44 Pen Mar, Penna.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Cardiac Vascular Disease</b> DUE TO (c) <b>47 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>March 27, 1967</b> , to <b>March 27, 1967</b> , that (I) (we) lost the deceased alive on <b>March 27, 1967</b> , and that death occurred at <b>11:45 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Robert A. Peter, M.D.</b>				22b. DATE SIGNED <b>28 March 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert A. Peter, M.D.</b>		
22d. ADDRESS <b>Blue Ridge Summit Pa.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/30/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burns Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro, Franklin, Pa.</b>		
24. FUNERAL DIRECTOR <b>Walter G. Grace</b>				25a. REC'D BY REGISTRAR <b>MAR 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04355

CERTIFICATE OF DEATH

04356

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Mem. Convalescent Hospital</b>		d. STREET ADDRESS <b>115 N. Main St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Louise Wheeler</b>		4. DATE OF DEATH Month Day Year <b>March 2, 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1882</b>
9. AGE (In years last birthday) <b>85 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours <b>1 6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Boonsboro, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Wheeler</b>		14. MOTHER'S MAIDEN NAME <b>Laurette Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Charles L. Meredith, Boonsboro, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cancer of maxillary bone</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>and metastases</b> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 19 67</b> to <b>March 2, 19 67</b> , that (I) (we) last saw the deceased alive on <b>March 1, 19 67</b> , and that death occurred at <b>11 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G. W. Levan</b>		22b. DATE SIGNED <b>March 3, 19 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. Levan</b>		22d. ADDRESS <b>Boonsboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-4-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1972

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04357

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GOLDIE DOROTHY DAY-WHITE</u>		4. DATE OF DEATH <u>March 22 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1888</u>
9. AGE (In years) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Tyson Dameron</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>523-30-0086A</u>	
17. INFORMANT <u>Eldon J. Day</u>		Address <u>2417 Penna Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Intercerebral hemorrhage</u> DUE TO (b) <u>athrosclerosis, cerebral</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; incidental fracture, left hip</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>XXX</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell at home while getting into bed on 3/14/67</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:00 p.m. 3/14 19 67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Hagerstown</u> (County) <u>Wash.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.		22. DATE SIGNED <u>3/22/67</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		23a. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF <u>3/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cemetery</u>	
23d. LOCATION (City or Town) <u>Hagerstown Md</u>		23e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23f. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23g. LOCATION (City or Town) <u>Huntsville Randolph Co Mo</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

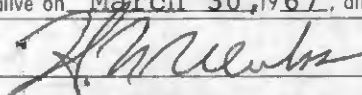
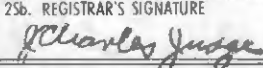
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04357

04358

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>14 Months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dollie May Wolfe</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 8, 1876</b>
9. AGE (In years last birthday) <b>90 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Zittletown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Siman Summers</b>		14. MOTHER'S MAIDEN NAME <b>Ema Zittle</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-48-6193</b>	
17. INFORMANT <b>Mrs. William Lowery, Rfd. 4, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Mesenteric thrombosis</b> DUE TO (b) <b>arteriosclerotic disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>  <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January, 1966</b> , to <b>March, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 30, 1967</b> , and that death occurred at <b>A</b> M, from causes and on the date stated above.			
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22b. DATE SIGNED <b>3/31/67</b> 22d. ADDRESS <b>580 Northern Ave. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4- 1- 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Best, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 3 1967</b> 25b. REGISTRAR'S SIGNATURE 	

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